REPORT RESUMES

ED 018 024 EC 001 056

COORDINATING SERVICES FOR HANDICAPPED CHILDREN, A REPORT OF THE NATIONAL INSTITUTE ON SERVICES FOR HANDICAPPED CHILDREN AND YOUTH.

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NATIONAL REHABILITATION ASSN. INC., WASH., D.C.

NATIONAL SOCIETY FOR CRIPPLED CHILDREN AND ADULTS

PUB DATE 64

EDRS PRICE MF-$0.50 HC NOT AVAILABLE FROM EDRS. 71P.

DESCRIPTORS- *EXCEPTIONAL CHILD SERVICES, ORGANIZATIONS (GROUPS), GUIDELINES, CHILDREN, YOUTH, VOLUNTARY AGENCIES, INTERAGENCY COORDINATION, FEDERAL PROGRAMS, STATE PROGRAMS, INTERAGENCY COOPERATION, COORDINATION, CLINICS, VOCATIONAL REHABILITATION, ADMINISTRATION,

THE REPORT AND ITS GUIDELINES SUMMARIZE VIEWS EXPRESSED IN SEVERAL PAPERS AND CONFERENCES SPONSORED BY THE NATIONAL INSTITUTE ON SERVICES FOR HANDICAPPED CHILDREN AND YOUTH. THE PURPOSES OF THE INSTITUTE ARE DEFINED. GUIDELINES DEVELOPED BY PRELIMINARY COMMITTEES AND REFINED BY CONFERENCES COVER FIVE AREAS--COOPERATION AMONG VOLUNTARY ORGANIZATIONS, STATE INTERDEPARTMENTAL COOPERATION, COORDINATING SERVICES AT THE INTERMEDIATE LEVEL, COMPREHENSIVE DIAGNOSTIC AND TREATMENT CENTERS, AND COORDINATION OF SPECIAL EDUCATION AND VOCATIONAL REHABILITATION. ALSO INCLUDED IS A CHAPTER DESCRIBING FEDERAL PROGRAMS FOR HANDICAPPED CHILDREN AND YOUTH. FIVE APPENDIXES LIST THE STEERING COMMITTEE, AGENCY PARTICIPANTS IN THE PRELIMINARY CONFERENCES, MEMBERS OF SPECIAL STUDY COMMITTEES, THE DISCUSSION GROUP LEADERS AND RECORDERS, AND AUTHORS OF INSTITUTE PAPERS. THIS DOCUMENT IS AVAILABLE FROM THE COUNCIL FOR EXCEPTIONAL CHILDREN, NEA, 1201 16TH STREET, N.W., WASHINGTON, D.C. 20036, FOR $1.50. (DF)

ED018024

Coordinating Services for Handicapped Children

C. Esco Obermann

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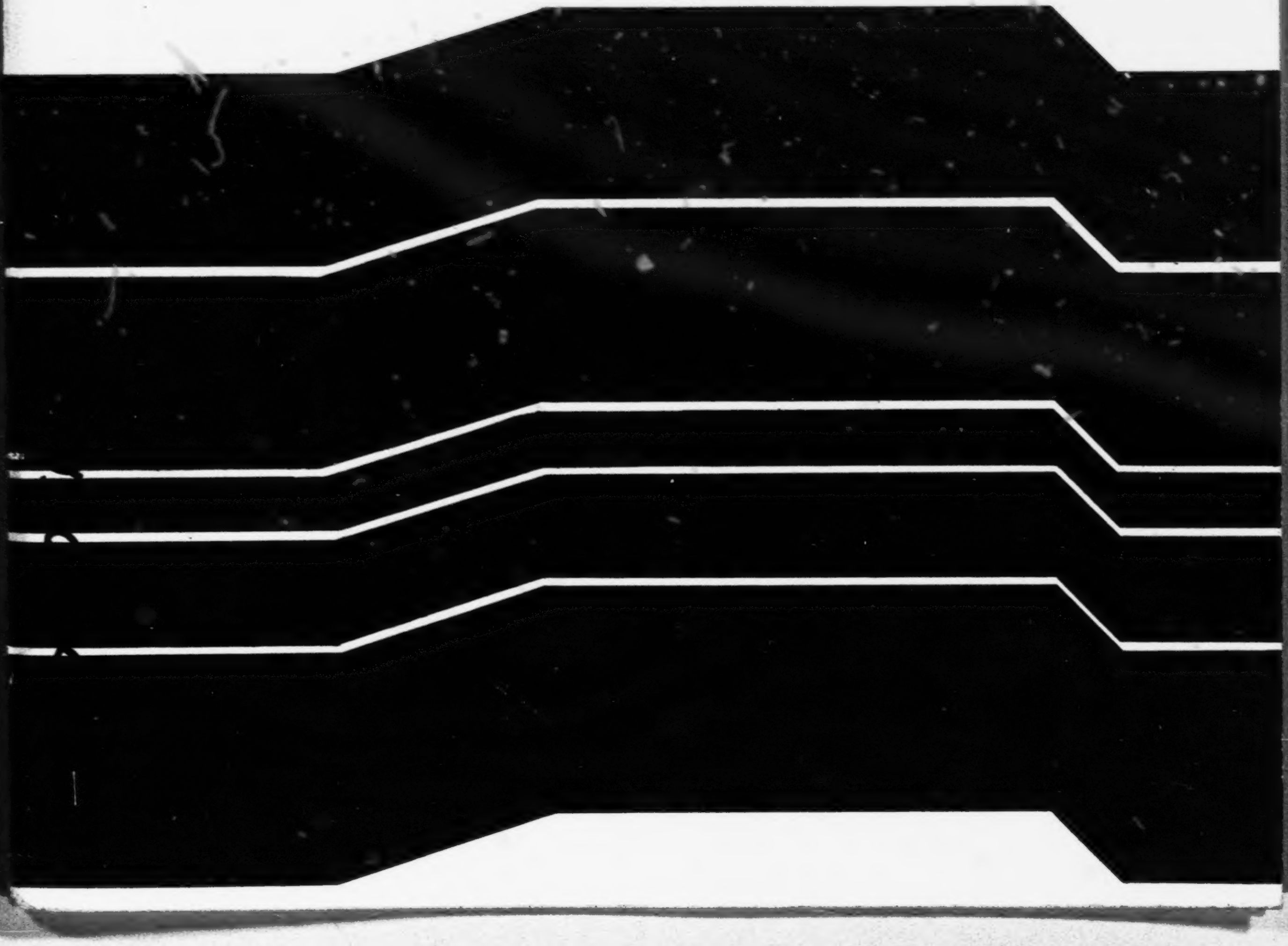

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Coordinating Services for Handicapped Children

A Report of the National Institute on Services for Handicapped Children and Youth

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Published by The Council for Exceptional Children, NEA and the National Rehabilitation Association, Inc.

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION

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Library of Congress Card Catalog No. 64-8407

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This Institute was supported by grants from the Vocational Rehabilitation Administration, Department of Health, Education, and Welfare, and the Easter Seal Research Foundation.

Preface

Neither this report nor the "guidelines" should be regarded as reflecting the official views of the sponsors, the grantors, or of any participating association, agency, or individual. *Coordinating Services for Handicapped Children* is a composite summary of many views, opinions and conclusions expressed in papers and in conferences sponsored by the Institute. The "guidelines" have been drawn from the materials presented in the papers and at the conferences. They do not represent the unanimous conclusions of the sponsors, the grantors, or the participants.

The basic papers prepared for and presented at the meeting of the Institute in Chicago in March, 1963, were reproduced and bound and received some limited distribution to purchasers who requested them.

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1

Aims and Goals of the Institute

The Golden Anniversary White House Conference on Children and Youth, held in 1960, had as its basic purpose "to promote opportunities for children and youth to realize their full potential for a creative life in freedom and dignity." From that conference came an outpouring of statements, resolutions, and suggestions reflecting the deep and thoughtful concern of several million people for the present and future welfare of the nation's children and youth. Many persons interested in the special imperatives for handicapped young people, however, felt that the White House Conference was not designed or equipped to consider in depth most of the issues related to this special category of youngsters.

Consequently, in 1962, there was established a National Institute on Services for Handicapped Children and Youth under the sponsorship of The Council for Exceptional Children, the National Rehabilitation Association, and the National Society for Crippled Children and Adults. It was financed by the US Vocational Rehabilitation Administration and the Easter Seal Research Foundation. Oscar Kurren served as director of the institute.

The purpose of the institute was to consider the special requirements of handicapped children and youth; to define the accomplishments and the problems of agencies, bureaus, organizations, and professions devoted to serving disabled young people; to explore how they might serve these youngsters better; to formulate some guidelines for further action.

The organizers of the institute proceeded on some knowledge and on many assumptions. A basic assumption was that handicapped children must be included among those for whom there should be opportunity to realize "full potential for creative lives in freedom and dignity." Another assumption was that services to handicapped children are generally inadequate. Although many agencies and organizations devote considerable money and manpower to meeting the medical, educational, and other requirements of disabled children and youth, whole categories of conditions are in need of more care than they now receive. The assumption was also made that such resources as are now applied to these problems could be made to yield more than they do if organizations and people could better coordinate what they have to offer. Much has been written and said on this subject, but performance lags behind concepts and resolutions.

In organizing the institute it was assumed that leaders in the disciplines devoted to serving disabled children and youth would want to engage in a national discussion of the many problems related to their work; that they would gain new insights from such discussion; that they would be able to carry new initiative and new practice back to their respective places of work.

A dynamic society normally outgrows static institutions and requires that attitudes, emphases, and energy distributions be flexible to remain effective. Even if all the problems had been solved and social functioning had been at optimum efficiency at some time in the past, the task of maintaining effectiveness would be enormous today. As stated in *Alice in Wonderland*, one must run very fast just to stand still. Perception of new problems, new insights into better ways of functioning, new ideals, new morals, all tend to make what was good enough only a few years ago seem obsolete today.

The National Institute on Services for Handicapped Children and Youth was designed to explore how to exploit existing resources and the opportunities arising out of social and economic change that could make the lot of such children and youth progressively better.

It was determined that the institute could most effectively address itself to six basic groups of questions:

1. Have the allocations of time, money, and functions of agencies been modified to meet the current needs of candidates for service? Are there procedural restrictions in some agencies that interfere with joint planning and cooperation with other agencies?

2. How have changing conditions altered functions of tax supported agencies on the one hand and voluntary agencies and organizations on the other? How do these changing roles affect them individually and what are the implications for joint planning and collaborative practice? Where the services of one have impinged on the others, how have the resulting problems been resolved?

3. What communication problems have developed among agencies due to the great growth in scope and variety of community facilities and services since World War II? To what extent are these agencies working together in case finding, in uniform reporting procedures, and in intercommunication? Are interagency case conferences held to plan

as rationally and as economically as possible for diagnosis, treatment, training, and followup from initial contact to a job and independent living?

4. Are there adequate legal provisions for comprehensive educational and rehabilitation services to handicapped children in the various states? What problems exist in interagency planning where legal definitions of a handicapped child restrict services to certain diagnostic groups, excluding others?

5. In what ways, if any, are the agencies working together to recruit and train professional personnel?

6. How has increased specialization, both in professional personnel and in service, affected joint planning and collaborative practice?

Under the guidance of a steering committee of representatives of the sponsors and other specialists, the institute held four preliminary conferences—in Baltimore, Atlanta, Minneapolis, and San Francisco. At these conferences the representatives of pertinent agencies (see Appendix B) defined and discussed cooperative plans and agreements in effect, reviewed some of the problems and difficulties encountered in developing them, and discussed suggestions for formulating effective interagency relationships. The fruits of these deliberations and the reports of five special study committees (see Appendix C) were presented at a national meeting in Chicago, March 11 - 14, 1963. These reports and subsequent discussions form the basis of this report.

The results of the institute and the conclusions that might be drawn from them cannot be considered to be definitive, but it is felt that in their exploration of the principles, processes, and problems involved in the operation of national, regional, state, and local activities, the participants in the institute identified procedures which apply to some of the more fundamental areas of concern and interest to all communities. The importance of a new approach to such problems becomes apparent when it is realized how much has been accomplished recently in developing new knowledge in medicine, public health practice, rehabilitation, and education. What is lacking is the development of efficient community structures for bringing to bear this new knowledge in charting an integrated program of health, education, and welfare services to the young handicapped individual. It is hoped that this institute may be the beginning of more comprehensive organization and utilization of expert knowledge in solving these problems.

In the body of this report, Chapter Three provides a summary of three papers which were not read at the conference but which served as background information regarding the functioning of three agencies of the federal government. They were prepared by the Exceptional Children Branch of the US Office of Education, the Office of Vocational Rehabilitation, and the Children's Bureau, all in the Department of Health, Education, and Welfare.*

It will be noted that the emphasis of this report has been placed on administrative rather than technical prescriptions involving specific areas of disability. The basic goal was to define the problems and explore ways in which agencies, organizations, and members of various professions could better serve disabled young people.

It is hoped that the "Guidelines for Action" provide some basis for proceeding positively in improving the status and the prospects for handicapped children and youth. At the meeting in Chicago, attended by over 100 of the nation's leaders in planning and operating programs of services for these children, the theme was "Interagency Joint Planning and Collaborative Practice—A Framework for Effective Services to Handicapped Children and Youth." It may be reasonably hoped that these leaders did acquire some new levels of insight and motivation for interpreting and implementing the suggestions generated by that theme. Followup efforts will be needed to determine if progress has been made in practices and procedures that will upgrade the opportunities for disabled children and youth "to realize their full potential for a creative life in freedom and dignity."

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* The recent reorganization of the Bureau of Research and Development of the Office of Education has created the Division of Handicapped Children and Youth, eliminating the subsidiary Exceptional Children Branch. The Office of Vocational Rehabilitation is now the Vocational Rehabilitation Aministration.

2

Cooperation Among Voluntary Organizations

Voluntary and professional organizations and agencies which have a significant potential for serving disabled children and youth are numbered in the hundreds. Some of them are national in organizational and functioning scope; some are sectional; some statewide; many are local organizations without affiliations or interests outside the local community.

Although the accomplishments of voluntary organizations and agencies are impressive, their programs quite generally operate at less than full effectiveness. There are many needs of disabled children and youth which might be met but are not because these voluntary efforts are not coordinated. The reasons are many. Communication difficulties are common, involving specialized vocabularies, geographical distances, and divergent professional and service interests. Organizational differences also cause difficulties: strong, centrally organized groups versus loose federations; national entities versus local bodies; nonpolitical versus social action groups; broad versus narrow scope of services; professional versus lay control; service versus research versus educational goals. Other problems are accounted for by (a) psychological difficulties, such as fear of loss of identity, fear of sharing information, lack of trust; (b) lack of genuine conviction about the desirability of cooperative action, the tendency toward empire building; (c) possessiveness on the part of boards and staff; (d) suspected lack of reliability of capability or sincerity of the other organization (and it is always the "other" organization); and (e) reluctance to share or dilute the personal satisfactions of founders and directors that can accrue from having an exclusive mission.

Possibly for the many reasons outlined, the voluntary movement has not been distinguished by the type of interorganizational and interagency cooperation and coordination that is so urgently needed. Fifty years ago (April, 1913) Dr. Frederick R. Green, then secretary of the Council on Health and Public Instruction of the American Medical Association, called together representatives from 39 organizations active in the health field to explore how the national health activities of voluntary organizations might be more effectively coordinated. He apparently was discouraged by that meeting because two years later, in an article in the American Journal of Public Health ("Cooperation and Coordination of Voluntary Public Health Organizations," Vol. 5, 1915), he enumerated his grievances regarding the voluntary health organizations. His observations look very much like those that can be found in recent writings in which proliferation in the voluntary health field is lamented.

Thirty years later Selskar M. Gunn and Philip S. Platt made a broad study of voluntary health agencies (*Voluntary Health Agencies: An Interpretive Study*, Ronald, New York, 1945). Gunn and Platt were still concerned about the need for and the lack of effective cooperation which Dr. Green had noted. They were impressed with the phenomenon of organizations developing exciting new patterns of cooperation within their own memberships and at the same time lacking the recognition that the same approach should govern their relationships to other agencies and organizations.

Policy statements of many national voluntary health associations indicate a definite awareness of the importance of consulting and joining forces with other organizations. Many of them carry lists of other health organizations with which they consider they have close working relationships. However, these are usually unilateral declarations of intent promulgated by one organization. They are essentially self-directives with little evidence of mutual understandings or actual operational actions.

Cooperation among voluntary organizations, while not all that it could be, has not been entirely lacking. Through the National Health Council, the Health Careers Project has made significant contributions. Regular meetings of the council afford opportunities to support other projects to exchange ideas and to be remotivated to work with other agencies.

There have been some notable cooperative agreements made among voluntary organizations. For example, in 1950, the National Society for Crippled Children and Adults and the United Cerebral Palsy Association formalized an arrangement to share statistics and to respect and honor the fund raising dates of the other agency. In 1962, the National Association for Mental Health and the National Association for Retarded Children moved forward by entering into and jointly issuing a memorandum of understanding. The seven agency committee has, for the past five years, regularly brought together seven large national health organizations for purposes of coordinating and sharing information. The National Health Council has been effective in promoting cooperation in several important areas.

Cooperation has been effected, at least in token measure, in legislation efforts, in working out formats of operations with federal agencies, research, fact finding activities, developing technical standards, uniform accounting, information exchange, training and staff development, recruitment, and demarcation of operating boundaries. An excellent project on the elimination of architectural barriers, in which the National Society for Crippled Children and Adults took the leadership, but in which many organizations cooperated, has been completed.

There has been some cooperation in fund raising and in setting standards for fund raising. The united fund approach has shown promise in many communities, although in some places there have been illustrations of how a good idea can be unexpectedly hazardous to the basic reason for existence of voluntary agencies. United fund councils or similar echelons have often undertaken to direct in too great detail the operations of cooperating agencies. They have been guilty of stifling the all important initiative of agencies and subjugating them to an unnecessary and inadequate master control mechanism.

There have been numerous complaints that the basic purpose of a united fund has been to serve those in the community who wish to keep contributions limited rather than to serve the ultimate clientele—the beneficiaries of the funds. In many united funds, increases in year to year allocations tend to be uniform, and uniformly inadequate to meet new program demands. Agencies with expanding missions and leadership adequate to their tasks are thus equated with agencies with static programs or unimaginative leadership. Agencies are often, by the terms of their agreements with united funds, barred from accepting contributions directly from donors.

The experience that some agencies have had with united funds should not generate a resistance to all forms of cooperation, including cooperation in fund raising. It only emphasizes the necessity for clear definition of goals, of expectations, and of functions and roles in cooperative arrangements. Cooperative fund raising should not be permitted to inhibit the unique and essential contributions that voluntary agencies can make—keeping service and research programs dynamic and filling gaps that tradition-and-restriction-bound entities cannot or do not fill.

The social and environmental problems affecting children and youth are so complex that agencies must cooperate if these problems are to be dealt with effectively. Voluntary agencies are needed to bridge gaps which so rapidly develop in our dynamic society. No single agency can stand alone to face the many tasks presented. The clientele to be served need help in adjusting to and accommodating such vital conditions as: (a) urban sprawl—which leaves the individual with no neighborhood and no community cohesiveness and is a strong anonymity producing force; (b) greater mobility—which isolates the family and the individual from the stabilizing influences of home and friends; (c) automation—which forces job and skill changing at developmental stages not convenient to the family or the worker; (d) low income—which still is an acute and chronic problem for millions of people and generates need for help in education, health, housing, welfare, wage standards, and employment; (e) the spread of government services—which requires better interpretation of the roles of voluntary agencies and programs.

It would be naive for the management of any voluntary organization to proceed into such a maelstrom of problems without structuring the best strategic situation possible. As in any struggle, intense attention should be given to the allied forces that can be mobilized on all sides of the front to be attacked. Use should be made of the most modern technical equipment and practices, such as computers, standardized labeling, frequent re-evaluation of mission and the mission of those in the same or contiguous fields. Obviously this requires cooperation of a high and continuing order.

Voluntary agencies have problems of defining their purposes, of maintaining quality programs, of structuring their operating machinery, and of financing. They have little or no control over many of the important factors and conditions they must take into account in solving these problems. It behooves them, therefore, to exploit fully those factors which they can control: frequent re-examination of programs, purposes, and structure; efficient alignment of internal organization and cooperation with other agencies. Attention to these things can generate strength to meet the demands that the uncontrollable factors generate: competition for funds, growth of government into nongovernmental fields of service, changing community structures, changing attitudes towards people and their disabilities.

Necessary Prerequisites to Effective Coordination

It is most important in establishing cooperative arrangements that organizations and agencies clearly define their individual objectives and goals and the objectives and goals they hope to achieve through working together. Goal defining begets planning and planning leads to action. It is suggested that the basic goal should be services to people—to disabled children and youth. It is sometimes too easy to let the organization and its needs become the dominant consideration. This is not to imply that organizational or agency strength is incompatible with an effective service program. Quite the opposite is true. It does take stability of organization to undergird a service program of optimum strength. However, the focus should be on the child and his problems that need to be solved rather than on the organizations themselves.

Certain other factors need consideration when attempting cooperative programs. An agency must not be required to give up too much in order to become a member of a team. The arrangement made should be one that promotes continuing satisfactions and a resolution to maintain the arrangement.

Not only should cooperative agreements avoid excessive sacrifice on the part of any one agency, but there should normally be a *quid pro quo* situation. Cooperation will persist as a desirable practice if a mutually beneficial relationship can be developed.

In planning for cooperative action at any level there should be assurance that the goals and the actions are approved at all levels. The full range of the organization should be willing to implement the plans. For example, the NARC-NAMH memorandum makes no mention of any commitment at the lower and operating levels. If the contemplated cooperation does not take place there, the agreement could be useless.

Planning, coordination, and cooperation bring results just from the experience they provide. First of all, it can be expected that these experiences will generate still more planning, coordination, and cooperation. Second, some elements within the organization will almost certainly be disappointed in the results. This is because some might anticipate greater efficiency of operation while others might look for a better quality of program. A joint arrangement might produce some of both but usually not enough to satisfy all who have expectations. Third, a whole new set of problems will be developed just because there is joint planning, coordination, and cooperation.

Great categories of problems are needing cooperative action by organizations serving disabled children and youth. The whole broad problem of disability (physical, psychological, educational, vocational) in our culture is likely to be best attacked through working with disabled children. The solution will not be found in health practices alone. Public education and public welfare probably have the dominant responsibility. There is a need to find the best combinations of effort among health, education, and welfare and between public and voluntary agencies in those areas.

Another category of problems pressing for solution is the shortage of professional and leadership personnel. Bold new solutions should be found and tried. Communications among the professions and between the professions and the public concerning disability, social responsibility, etc., are in great need of improvement. Our practices and our techniques for reaching common understandings are still primitive. Too often the confusion results in people of basic good will struggling against each other rather than against the evils they wish to eradicate. Voluntary effort in our society is a great and beneficent force. It should be made free of the handicapping conditions of noncooperation and noncoordination. Intelligent, devoted people in the voluntary movement should move aggressively to establish conditions in which the full force of the good that people intend shall be brought to bear on the problems they are dedicated to solve.

GUIDELINES FOR ACTION

1. The full range of a child's needs and potential should have the focus of attention. The immediate problem should be evaluated by each organization concerned with that child in relation to his physical, psychological, social, familial, and vocational characteristics, potentials, and needs.

2. Joint understandings should be delineated between voluntary agencies and/or governmental agencies.

3. Each organization should clearly define its individual objectives, role, and goals in any joint cooperative arrangement.

4. Cooperation should be mutually beneficial. No one agency should have to sacrifice too much to cooperate with others.

5. Cooperation planned at local, state, or national level should have assurance that the agreements and goals are approved and will be supported at all levels.

6. Voluntary organizations should give priority to cooperative action in: (a) establishing optimum working relationships among health, education, and welfare agencies, and between governmental and voluntary agencies in those areas; (b) solving the crucial problem of the shortage of professional and leadership personnel to serve handicapped children and youth; and (c) improving professional and public understanding of disability and society's responsibility for its alleviation.

7. Voluntary organizations should be encouraged to cooperate in filling in the gaps in services to handicapped children and youth which will continue to develop in a dynamic society.

8. Re-examination of programs, purposes, internal structure, and cooperative arrangements should occur frequently and systematically and preparations should be made to effect changes as indicated.

9. The need and obligation to remain flexible and able to make changes to meet newly revealed demands while fulfilling basic missions should be protected by any organization when entering into cooperative arrangements, such as fund raising.

3

Federal Programs for Handicapped Children and Youth

There are many programs and activities of the federal government which are concerned with handicapped children and youth. They are mainly in the Department of Health, Education, and Welfare, although some are to be found in the Department of Labor and in the Veterans Administration. In this report a brief summary is presented of the programs either directed or supported by the Division of Handicapped Children and Youth of the US Office of Education, the Children's Bureau, and the Vocational Rehabilitation Administration—all in the Department of Health, Education, and Welfare.

The education of exceptional children is a part of the total program of American education. In the US Office of Education, the newly created Division of Handicapped Children and Youth will serve as the central place for administering training and research funds, for collecting and disseminating information, for consultation, for the conduct of studies, and for related services that affect the education of handicapped children who have unusual educational needs. These needs might result from physical, sensory, or psychological limitations, from mental retardation, or from serious social or emotional maladjustment. The Children's Bureau of the Department of Health, Education, and Welfare is concerned mainly with the medical needs of children and youth. This can include social and emotional situations that might affect optimal recovery from other health conditions. The bureau can also participate in programs to minimize emotional and social disability.

The Vocational Rehabilitation Administration may give support to programs involving medical diagnosis, reduction of disability, counseling, or training and job placement. These activities are directed mainly to those youths who are old enough to be candidates for the work force and whose physical or psychological impairments are such as to require special services to make them optimally employable. Some support is also given to the prevention of vocational problems, as indicated by the support VRA has given to 41 occupational training centers for the mentally retarded and to seven public school dropout programs.

Obviously, there are opportunities for coordination among these agencies. The service operations in which they participate or to which they give support are generally controlled at the state or community level; but in making policy, collecting and analyzing data, disseminating information, making grants to programs and projects, preparing legislation, etc., there is much to be gained by working cooperatively.

The general responsibility for the education of the nation's children and youth resides in the states and local communities. However, there are certain unique functions that can best be performed by some general agency such as the federal government. This was recognized as early as 1867 when the US Office of Education was established by a congressional act "... for the purpose of collecting such statistics and facts as shall show the condition and progress of education in the several states and territories and of diffusing such information respecting the systems, and methods of teaching as shall aid the people of the United States in the establishment and maintenance of efficient school systems, and otherwise promote the cause of education throughout the country." Later acts provided more specifically for activities affecting the education of exceptional children.

The Division of Handicapped Children and Youth works mainly through state departments of education, colleges and universities that prepare special education teachers, national organizations concerned with handicapped, and other federal agencies, including other units within the Office of Education.

The division has three major activities involved in administering federal laws relating to handicapped children and youth: (a) allocating grants-in-aid for research and for training special education personnel; (b) rendering consultative service; and (c) collecting and disseminating pertinent information.

Probably no more than 25 percent of the nation's children who need special education are now getting it, although the number doubled between 1948 and 1958. The division relates such information to the number of qualified teachers available to teach handicapped children and the extent to which colleges and universities are training more teachers so that more of these children may receive the special education services that they need. Other critical issues such as state laws, financial aids, and certification requirements are also studied and reported. The division identifies the most crucial gaps and the most critical issues in special education and undertakes to communicate these in the way most likely to promote corrective action. Good practices that might have general application are also publicized. It has been estimated that almost 50,000 additional special class teachers are needed for mentally retarded children alone, if all these children are to have access to a suitable education program. Under its grant programs to ease the teacher shortage, the division is emphasizing the training of promising persons who will assume the leadership of training others to become competent in special education or to take supervisory positions in special education programs. The division also provides funds for the training of classroom teachers, makes studies of standards in the preparation of special education teachers and distributes publications that report these studies. Opinion surveys are made among leaders and teachers to reveal developing trends in opinions and objectives. Through direct studies and grants the Office of Education collects, analyzes, prepares for publication, and disseminates information on all areas of special education.

In addition to the research grants provided through the Division of Handicapped Children and Youth, the Cooperative Research Branch of the Office of Education has financed about one hundred research projects directly or indirectly related to handicapped children.

The Children's Bureau makes grants-in-aid to state administered medical care programs financed by additional funds from state and local sources. The grants are made so that each state may extend and improve its services for locating crippled children (especially in rural areas and in areas suffering from severe economic distress); for providing medical, surgical, corrective, and other services and care; for providing facilities for diagnosis, hospitalization, and aftercare for children who are crippled or have conditions that might lead to crippling. In making grants, special weighting is given to states with low per capita incomes. Rural child populations are also given special weighting. These result in variable matching of funds.

Up to 12½ percent of the federal appropriation available to the Children's Bureau is reserved for grants to state agencies and institutions of higher learning for projects contributing to the advancement of services for crippled children. The grants from the Children's Bureau may be made only if the state submits an acceptable state plan for crippled children's services. The plan must meet certain specifications, including: financial participation by the state, cooperation with the medical, health, nursing welfare groups and organizations, and with any agency in the state charged with administering the state's laws for vocational rehabilitation. The services may include case finding, prevention, and treatment. They may also provide for attention to social and emotional situations which might affect recovery. Prevention may include not only prevention of the onset of crippling conditions, but also services that are needed to mitigate crippling and emotional and social disability.

The state agencies that qualify for grants-in-aid from the Children's Bureau hold clinics at various intervals and in various locations within the respective states. At these clinics children are examined, treated, and arrangements are made for hospitalization, appliances, etc., as indicated. Working with the physicians at the clinics are public health nurses, medical social workers, physical therapists, speech and hearing specialists, nutritionists. Diagnosis is freely available but consideration is given to the family's ability to pay for prescribed treatment and hospitalization. In 1962, the crippled children's program reached 335,000 children. This is 49 out of each 10,000 of population under the age of 21. The range among the states was from 15 to 124 for each 10,000. The incidence was highest among the states with the lowest per capita income levels.

Less than 50 percent of the patients have presented orthopedic problems. Since 1950 there has been a 595 percent increase in epilepsy cases accommodated in the program. There has been a 94 percent increase in congenital malformation cases and a 450 percent increase in patients with congenital heart disease. There has been over a 100 percent increase in those with hearing problems. These increases can be traced largely to the work that has been done by various categorical impairment, voluntary organizations. Possibly it also might be the result, in part, of better communication among professional specialists. There has been a significant decrease in number and duration of hospitalizations and an increase in outpatient activities in the program. In some states specific definitions exclude children from the program with such disorders as epilepsy, strabismus, loss of hearing.

A number of developments which may be expected in the future for the crippled children's program are:

1. It will probably grow in size. With five and a half-million births each year expected by 1970 the program should reach over 600,000 children a year just to maintain the current ratio.
2. There will be a closer tie with maternal and child health services. This need is emphasized by the fact that there are 30,000 babies born each year who have congenital heart disorders.
3. There will be a broadening of the definition of the term "crippling" in many states.
4. The program will be extended to urban areas. The assumption that the need is greater in rural areas does not lessen the need in the centers of population.
5. There will be an increase in the development of outpatient centers for children.

6. There will be an increasing utilization of psychiatric services so that more attention can be given to the social and emotional aspects of disability and illness and to functional disorders.

7. There will be more emphasis on multidisciplinary services and on closer coordination with teaching and research.

8. There will be closer ties with special education and vocational rehabilitation programs.

The vocational rehabilitation program in which the Vocational Rehabilitation Administration participates is often referred to as a state-federal program. This program was initiated in 1923 but went through some major developments under federal statutes passed in 1943 and 1954. Under the program the state agencies provide services directly to disabled persons. The Vocational Rehabilitation Administration has responsibility for supervising, surveying, setting standards, and making grants for the operation of the state program. The state agency that is responsible is usually a division of the state's department of education, although some states have set up independent commissions to conduct the program. In 36 states there are separate agencies for the rehabilitation of blind persons. These agencies are often a division of the states' public welfare departments. All of the 50 states, as well as Puerto Rico, the District of Columbia, Guam, and the Virgin Islands operate vocational rehabilitation programs under state-federal arrangement.

Prior to Public Law 565, (the Vocational Rehabilitation Act of 1954) the program provided for: (a) medical services to eliminate or reduce disability; (b) prosthetic devices needed to increase employability; and (c) counseling, training, placement and followup. Public Law 565 was an extension of previous legislation but it broadened the scope of that legislation by authorizing some sweeping changes in fiscal, professional, and technical aspects of the program.

1. The new act provided for federal participation in a broadened program and prescribed a formula for matching the funds appropriated by the states. This formula permits allocating proportionally greater amounts to states with small financial resources than to states with larger resources. The average participation is about three federal dollars for each two dollars contributed by the states.

2. Extension and improvement grants to states were authorized to permit state agencies to develop new aspects of their work and to extend them to disability groups and to geographical areas not previously adequately served.

3. Grants to states or to nongovernmental, nonprofit agencies were authorized for the support of research and demonstration projects.

4. To stimulate the training of more professional personnel in vocational rehabilitation, grants were authorized to qualified education-

al institutions for setting up programs of professional training and to qualified students who were interested in pursuing such training.

5. The act provided funds, to be used in combination with state funds, for the enlargement or alteration of rehabilitation centers and workshops to permit greater capacity for serving rehabilitation clients.

6. The law also authorized the establishment and operation of rehabilitation programs at the city or county level, to which federal and state funds could be allocated. Such programs are to be under the general direction of the state vocational rehabilitation agency.

Public Law 565 required that each state and federal employment service office designate at least one staff member to give special job counseling and placement assistance to disabled persons. It also increased the appropriation for the President's Committee on Employment of the Handicapped so that it could carry on (with affiliated governors' committees in the various states) a more aggressive educational and promotional campaign for the employment of disabled persons.

Under the state-federal program of vocational rehabilitation a state plan is required as a base for the agreement between the state and the Vocational Rehabilitation Administration. The plan must describe the state's authority, organization, regulations, policies, and operations with respect to vocational rehabilitation. These several state plans and their implementation are significant aspects of the services available for disabled children and youth. In most states vocational rehabilitation services may be offered to youth as young as age 15—the age at which they may legally enter the work force. By close cooperation with special education programs, with the programs for crippled children, and with other activities concerned with disabled children and youth, the vocational rehabilitation program supplies a continuity of service that can help young people to realize their optimum potentials. In some states these desirable working relationships have been well established. There are nine principal services authorized and provided by the state-federal vocational rehabilitation program. They are:

1. Medical diagnosis and evaluation.
2. Medical, surgical, psychiatric, and hospital services to remove or reduce disability.
3. Providing prostheses when indicated.
4. Vocational counseling and guidance.
5. Job and adjustment training.
6. Maintenance and transportation.
7. Providing tools, equipment, and licenses when needed.
8. Placement in a suitable job.
9. Followup to insure the success of the placement.

Approximately 3600 workers are employed in the state-federal vocational rehabilitation program. This is exclusive of the workers in the units in the states who rate disability status for the purpose of determining eligibility for social security disability payments. These units are usually administered by the vocational rehabilitation agencies.

In 1962 over 100,000 disabled persons were rehabilitated in this program; about one-fifth were under age 21.

4

State Interdepartmental Cooperation

The basic documents that founded our republic allocated to the several states the major role in providing for the education and welfare of our citizens. Transportation and communication being what they were in the early history of the country, it was necessary to delegate many of the states' responsibilities to counties, townships, or local districts. These political subdivisions still function as the major operating echelons in health, education, and welfare. However, changes in taxing prerogatives and tax sources, along with a multitude of other socioeconomic and technical developments have made it possible, and sometimes mandatory, for state level bureaus and departments to exercise an ever-growing influence and participation in meeting the needs of the people in their local communities. As this trend continues, it becomes more and more important that the various state departments and services work in unison in their functioning. Many health, education, and welfare lines lead directly or indirectly from individuals to state departments and bureaus. Failure to coordinate these services can and does result in inadequate casework and faulty individual client diagnosis, planning, and servicing. Lack of coordination in a state bureaucracy is not necessarily indicative of a resistance to the principles of cooperation and joint action. There is evidence that much of the difficulty can and does arise from a need for better definition or description of key terms and of the operations where coordination and cooperation would be feasible and profitable. This requires a clarification of the meaning of such terms as "identification," "diagnosis," "evaluation," and "counselling." Is *mental retardation* an *illness*? Are *delinquents* included among the *handicapped*? Care must be taken, however, not to define such things as handicapping conditions so rigidly that creative thinking is stultified and dogmas established.

In addition, there is needed a format or philosophical synthesis applicable to state level interagency operating. State departments have frequently been established with little attention being given to the basic theories and principles of state functioning. A law is passed, appropriations are made, office space and equipment are provided, personnel are hired, regulations are written and a new department is in business, or an established department has moved into a new area of operation. But the department head and his staff may be so preoccupied with their own internal organizational problems, i.e., writing job descriptions, programing, recruiting and training personnel and housekeeping requirements, that there is little time to engage in conferences with staffs of established departments to insure efficient articulation of the new operations with those already in the field or a closely related field. It will be necessary to clarify and evolve theory relating to interdepartmental processes and to develop the philosophical synthesis necessary in understanding the *function* of an organization before its *structure* is defined.

Furthermore, there seem to be too few empirical studies to discover, describe, and evaluate various cooperative arrangements that have been tried, are being tried, or might be tried. Some empirical studies of governmental functioning have been made, but there is a lack of scientific resources being utilized to organize comparative data around theories about the desirability of this type of interdepartmental cooperation. Among state departmental agencies the opportunities to initiate such interrogations are many. These agencies should be guided into inquiry concerning effective ways of cooperative functioning. State interdepartmental cooperation is frequently inhibited also by the barriers imposed by existing laws or regulations or policies. Typically, new laws are placed on the law books as the result of intensive work by persons and organizations interested in having the laws passed. They seek to protect the entities and functions to be established by new legislation, by having excluding provisions incorporated which will allow little or no influence or control except by the bureau, department, or division being created. When the implementing regulations are written they are also likely to provide further safeguards against interference. Over a period of time, policies can be formulated that will further insulate the operating entity from influences originating outside its own structures. Under such conditions interdepartmental cooperation becomes quite difficult. Only the most sensitive and astute leadership can succeed in easing these conditions.

Personality barriers likewise serve as inhibitors of cooperation. Many professional people in the various departments (as in voluntary agencies) may have had relatively narrow and specialized training, may have unique professional and personal aspirations, or may find coordinating to be a threatening requirement. Professional responsibilities are sometimes sacrificed to personal aspirations for power or to ego satisfactions. Other barriers to interagency cooperation would include such things as the influence of special interest or political groups, autocratic methods of administration and decision making, and the danger of administrative demands superseding services.

The Process of Coordination

Beginnings in coordinating state departments are usually made by persons of initiative and conviction who initiate conversations that later lead to extended dialogue involving many people and agencies and this dialogue can be expected to culminate in action. Such beginnings in coordination are usually stimulated by discontent over unmet needs. Typically, some temporary solutions are provided through structures that become more complex as more problems are revealed. Ultimately, persons who perceive that organizational and administrative ramifications are impeding operations suggest an attack on Parkinson's Law, and dialogue begins—hopefully followed by action again. Initial dialogue leads to expanding dialogue and the situations and solutions tend to clarify. It would be unfortunate, however, if the continuity of discussion and exploration were to stop when the first actions have been taken. Through discussion coordinating groups try to obtain all the facts about both the specific and the general problems, and attempt to find solutions.

It is important here to stress the necessity of problem oriented solutions and the importance of keeping in mind that the function comes first and the structure follows, to avoid ending up with a coordinative structure but sterile dialogue. Structure should continue to evolve as functioning reveals the need for change. A dynamic society in which there are new and emerging standards of social responsibility, new and developing values, and new economic relationships, makes necessary constant review of all programs for children and youth. The leadership that is especially concerned with disabled youngsters recognizes that if changing from a rural to an urban society, changing from crafts production to automation, changing from a static to a mobile population generates problems for children—it generates problems with a double depth of intensity for disabled children. It is a function of leadership to anticipate the needs emerging from change, to create readiness for change, and to insure that the passage from the old to the new is accomplished efficiently.

It should be accepted that the patterns and theories of cooperation and coordination among the states' departments which offer services affecting disabled children and youth will not be uniform from state to state. Differences in basic state laws, in administrative structures, in staffing patterns, in levels of sophistication and maturity, in traditions, in the demands of those initiating cooperative action, in political commitments, in the kinds and types of existing resources, etc., will result in uniqueness of approaches and results. In most states there is opportunity and need to make some progress towards eliminating duplication, reducing friction, integrating staffs, and allowing better use of technical abilities. Preoccupation with the special problems arising out of uniqueness should not be permitted to be a source of frustration and a barrier to action in any state.

The New York State Interdepartmental Health and Hospital Council was formally organized in 1960, replacing the Interdepartmental Health Resources Board which had a long history of adaptation to unique needs and the function shifting process. This council is composed of the commissioners of health, social welfare, mental hygiene, education, and insurance. It was assigned the following specific duties:

1. To conduct joint study, planning, and program development concerning two or more departments.
2. To serve as an organized medium of exchange of information among member agencies.
3. To consider new aspects of health problems facing the state and to develop appropriate approaches or recommendations to the governor as indicated.
4. To establish a framework for interdepartmental consultation.
5. To study problems of personnel recruitment and training in health disciplines utilized by two or more departments.

Effective committee operation has included other state departments or agencies. The committee on rehabilitation, for example, has effectively coordinated the services of eight departments. The New York Council as a whole does not operate projects (as did its predecessor), but concentrates on interdepartmental program study, planning, and development.

Another example of interagency coordination with a long history of continuous interaction and dialogue is the Illinois Commission for the Handicapped. The membership of this commission is composed of the heads of the state departments of mental health, labor, public health, public instruction and also nine prominent citizens from the state appointed by the governor. There has been little shift in organizational structure in the last twenty years and its committee system of operation has a good history of accomplishments. This commission recently has emphasized support and guidance to the development of services in or by the local communities and to working with individual voluntary and public agencies which are attempting to develop or upgrade their services for handicapped people.

Of more recent origin in Pennsylvania, the Governor's Committee for the Handicapped is composed mainly of members from outside the state organization of government. These members are recognized medical and special education representatives from the universities or public education. Charged with preparing a comprehensive plan relating to both public and private agencies to serve as a legislative and administrative guide for both local and state programs for handicapped persons, this committee recommended, in 1962, the creation of a governor's commission for the handicapped, responsible directly to the governor.

The California Coordinating Council on Programs for Handicapped Children was established in 1961 to meet the need for a single state agency to coordinate and plan for services to handicapped people. This is a still emerging operation at present. The council is composed of the directors of education, mental hygiene, public health, and social welfare of the state government, with the possibility of adding a fifth member—the director of the California Youth Authority. A unique and effective aspect of the administration of this council is the staff organization under which each member of the council has a staff representative. This staff of highly qualified members of the respective departments meets on a monthly basis, acting on recommendations from the council's quarterly meetings. Meeting with the council are representatives from the governor's office, the Department of Finance, the Youth Authority, and the Health and Welfare Agency.

There appears to be a trend toward centralizing official state interagency coordination of services to handicapped people. Increased acceptance has evolved gradually and usually after pragmatic experience with some type of interagency dialogue, during which one or more of the following functions has appeared:

1. Improving and extending existing statewide services.
2. Implementing local services to the handicapped.
3. Preventing costly time lag between discovery and use of medical and other knowledge.
4. Provision of wise and economical use of both public and private monies.
5. Giving major attention to orderly and planned growth in the field of programs and services to handicapped people through recommendations to the legislature regarding needed or proposed legislation.
6. Continuous review of programs and services being offered to physically and mentally handicapped people, by both state and local agencies.
7. Influencing federal legislation.

Councils, commissions, committees, and boards have taken many forms, included varying department participation, and have worked towards many goals. Generally, the departments of education, welfare, health, rehabilitation, corrections, mental health, and labor have been involved.

In some states there has been an attempt to involve, also, representatives of voluntary health and welfare agencies. There is some reluctance on the part of persons experienced in state coordinating activities to include voluntary agencies. They suggest that voluntary agencies have a different basic role in health, education, and welfare from that of political departments and bureaus; while the latter should administer tried and proved programs of services, voluntary agencies should address themselves to research, demonstration, and creative development. Voluntary agencies, unhampered by the legal safeguards required for tax-supported agencies, can be more daring in what they undertake; they can exercise more imagination in leadership. To involve voluntary agencies too deeply in the work of state coordinating councils would tend to remove them from their vital role of pioneering and experimentation in many ways other than administrative. Operationally speaking, there has been an increasing awareness of the *method* of coordination, and an attention to working relationships, but little progress in empirical measurement of the *effectiveness* of the coordination. Lack of staff and lack of funds have been problems common to all of these coordinating efforts.

The importance of a better public concept of the need for funds and staff is recognized by agencies that promote services for handicapped children and youth. The merits of education are obvious. But education goes beyond formal school organizations, for it becomes the concern of government at all levels, as well as of private agencies and volunteer groups. Some believe that a public information program should be carried out cooperatively with government and volunteer agencies to inform the public on the magnitude of the problem in perspective, with the large number of specific problems delineated within this frame of reference. Since at the present time most information emanates from particular groups interested in particular programs, it may be painful to individual groups to merge their particular objectives with those of other groups. A number of pilot projects properly supported and staffed could demonstrate how this might be done and could be used as models for initiating such projects at the state level and even at the federal level.

Through organized education a beginning has been made in accepting the idea that the education of handicapped children is a community problem. The integration of handicapped children into the regular school system is a first step toward coordination of services. Attitudes are established early, and day by day contact sets the stage for all citizens. The school itself, through its ancillary services and contacts with outside agencies, can make some headway in interagency coordination. More needs to be done. In the area of vocational rehabilitation, for example, better coordination needs to be effected between the school and the agency which will carry on after the school years.

At the level of higher education, an effort must be made to allow students to begin to practice with members of related professional groups with which they will later come in contact. This requires a broader interdisciplinary approach to professional training which becomes more difficult as the special requirements for each professional discipline become more extensive and complex. There is too little time in a curriculum to "cross train." Professional specialists lose the skill of cross communication; they develop specialized techniques and limited goals. If they bring these limitations to the planning and the implementation projects, they often fail to see the broad implications and requirements of the cooperative effort, and they become inhibitors rather than facilitators. Some colleges and universities are making attempts to provide more interdisciplinary experiences and their attempts should result in better trained people who in turn will be better able to solve problems of coordination.

There is much to be gained from a mechanism for interagency coordination on a state level. It can establish an organized procedure for the exchange of knowledge and services that each agency has to offer; it can facilitate communication among agencies; it allows for a global approach to study and research by permitting an exchange of information that may ordinarily have elements of restrictive confidentiality; it enables initial participation of all agencies in planning solutions to specific problems; it can aid in coordinating agency efforts and programs of mutual interest; it can reduce overlapping, fragmentation, and duplication of department services and activities; and most important, it can help to provide some measure of assurance that comprehensive services will be made available to disabled persons through joint and cooperative efforts. Many barriers inhibit the successful utilization of this approach, but some attempts have been made. With the derivation of empirical data, the establishment of workable theoretical bases, ongoing dialogue, and a desire to articulate and coordinate services, much may be accomplished.

GUIDELINES FOR ACTION

1. Empirical studies should be made to discover, describe, and evaluate various cooperative arrangements among departments at state levels that have been tried, are being tried, or might be tried. Uniqueness in structure and function in relation to the specific needs each is trying to fulfill should be accepted.

2. Certain philosophical and theoretical bases should be established such as the following:

- Operational definitions of terms and functions such as cooperation, coordination, and teamwork among state agencies should be clearly stated.
- A state interagency coordinating council should originate as an outgrowth of agency needs and desires to coordinate programs and services so as to provide better for disabled persons.
- Purposes and goals should be clearly defined. The structure of the organization should be provided in response to functional needs.
- The interaction should be one of cooperation, not that of an authoritarian superstructure.

3. The process of cooperation should be recognized to include:

- A continuing free flow of dialogue between and among members.
- A recognition of unmet needs and the purposes for establishing or continuing the state interagency coordinating council.
- Ongoing development, possibly of a slow maturing nature.
- Discussion, leading to action.
- Safeguards against special interest or political groups taking control.
- Movement from immediate self-concern of individual departments to cooperative concern for the needs of disabled people.

4. In the actual administration of state interagency coordinating councils, the following points should come under consideration:

- Basic and long range planning, setting of priorities, and agreement on implementation schedules should be accomplished before organizational structures are adopted.
- The state interagency coordinating council should be established as a result of official action—either by the legislature or by executive order—specifying purpose, structure, responsibilities, and membership.
- The council should be composed of high echelon executives of those agencies having direct concern with the purpose of the council, allowance being made for changing composition with changing needs.
- There should be a close working relationship with the governor's office, with reports and recommendations channeled directly to that office.
- There should be a full time, permanent, independent-of-departments staff, which is capable of assembling, analyzing, and interpreting data; organizing and assisting with studies; performing general staff duties; maintaining general council continuity.
- Channels for communication with voluntary and community agencies should be kept open, with citizens' advisory committees to provide information on community needs and program evaluation.
- Administrative needs should not supersede service.
- The goals, functions, and responsibilities of each member agency should be clearly defined and understood at all echelons of staff.

5. Certain personal qualifications are necessary for the smooth functioning of a state interagency coordinating council.

- Maturity, personal security, and sensitivity are necessary so that the members will not threaten or be threatened by other representatives, and so that the best interests of the disabled clientele will be met through impartial and objective action.
- There must be a sincere desire to interdepartmentalize.
- The representatives on the council should have extensive backgrounds in government organization with expertness in at least one of the department fields.
- An interdisciplinary background is to be desired in each member.
- There should be nonauthoritarian but stimulating leadership.

5

Coordinating Services at The Intermediate Level

Advantages can be demonstrated in coordinating available services at all levels of planning, direction, and operation. While the features of the activities of coordination might be different at various levels, and while the services to be coordinated might be different, the purposes of coordination remain essentially constant. These purposes include the more effective uses of money, skills, and facilities to the end that the clientele will be more effectively served. If the pattern and expectation of coordinating is set at national, state, or regional levels, there is a higher probability that services will be coordinated and related to each other in the local community where the patients and clients are.

As the operating level is approached, however, coordination becomes more difficult and demands greater leadership skills. The nearer the planning, development, and direction are to the operations, the more specific the problems and requirements become—the more apparent the personal, professional, and program differences become. The abstractions formulated and accepted at national or state levels are not as readily understood and accommodated in operations. At the operating level the moment of truth must be faced; theories, principles, and statements of intention are tested. This problem is heightened by the fact that the local operators have usually not participated in the formulation of the principles. Communications difficulties, differences in background of personnel, geographic and demographic peculiarities tend to amend, dilute, or make difficult the application of intentions agreed upon at national and state levels. The realities of indifference, ignorance, suspicion, insecurity, and resistance are probably more acutely encountered and in greater profusion where the actual operations take place. In many areas, services to handicapped children and youth can be made more effective if a coordinating entity is provided at what might be called the "intermediate" level. This would be between the local community and the statewide levels. Intermediate organizations can take many forms. They might cover a number of counties, or perhaps a single large county, a number of school districts, or a number of towns, villages, or suburbs. They can involve varying combinations of agencies. These communities might be definitely rural or they might be parts of a large metropolitan center. The already established resources might be many or they might be very limited. The purpose of such units is to plan, develop, supervise and, in some instances, provide services for disabled children and youth who are otherwise not likely to develop effectively and efficiently.

The lack of uniformity of population distribution has created unequal facilities for differing parts of the country. In widely dispersed populations there may be too low an incidence of certain types of handicapping conditions to warrant services. It has always been difficult to provide adequate and suitable services to rural children. Resources within reasonable distances can frequently be found in large cities and their surrounding suburbs, although even in these locations much is lost when these resources are not coordinated and integrated. In rural areas, however, the distances, the problems of communication and education, the dynamics of population movement, the lack of capacity to attract professional specialists, all emphasize the need for coordinating the services that are or should be available for disabled children and their families in those areas. These same areas, however, often have exaggerated—though geographically scattered—needs greater than those in the city. Out-migration has tended to drain away from distressed areas those whose vigor and leadership capacities are most needed to help solve the problems they leave behind them. Large proportions of the expansion in the nonagricultural labor force in recent years has been supplied by recruitment from low-income rural areas. Children too young or youths too handicapped to move to big-city jobs tend to stay behind with those too old to migrate. This increases the acuteness of the service needs in those areas.

It can probably be shown that the prevalence rates of disabilities among rural children are higher than among nonrural children. This might be expected because of the lack of corrective therapies in rural areas and the inability or unwillingness of families who are burdened with low income, ignorance, or with a disabled child to join in the migration to a metropolitan environment with its risks and unknown conditions. Therefore, unless existing resources can be more efficiently coordinated, new professional talent attracted, better communication and treatment established, the problems of handicapped rural children are likely to remain chronic. Nearly half of the children in the rural areas today will move to the cities tomorrow. Then they, their habits, their health, social, educational, and vocational problems become the concern of the cities that adopt them. Attitudes and conditions in rural districts, bred in neglect and ignorance, will help to shape the medical, social, educational and economic conditions of these cities which, themselves, still have far to go before all the needs of their disabled children and their families are met.

The supplying of more and better trained professional personnel compared to the total population has not automatically raised the level of services to rural communities. On the contrary, it can be shown that in many areas the professional resources available to farm and village families have decreased in recent years. Thinning rural populations and chronic economic distress in many agricultural areas have been factors making it difficult to attract professional persons into those areas. The intermediate type of organization is one well adapted to bringing better professional services to rural areas. It is well suited to effect coordination of such existing agencies and programs as might have been developed under various sponsorships. It can help to define the appropriate roles for schools, welfare offices, voluntary agencies, professional specialists, and families and individuals. It can promote a wider range and a more consistent continuum of services so often lacking when there is no coordinating medium.

In a study conducted in Minnesota in 1959,* the following was reported with respect to children and adults with cerebral palsy:

1. Only 34 percent of the patients living in rural areas, compared with 46 percent of those in urban areas, were under the care of a qualified specialist.
2. There were one and one-half times as many orthopedists and internists, twice as many opthalmologists and otologists, and three times as many pediatricians and neurosurgeons providing medical care to patients in urban areas as in rural areas.
3. A much lower percentage of rural patients had ever been seen at any time by an orthopedist, an opthalmologist, an otologist or audiologist.
4. Twenty-three percent of the rural patients had never received any therapy service (physical, occupational, speech), while only 13 percent of the urban patients had been without such service.
5. Much higher percentages of rural children than urban children of school age were not in school, were attending nonspecialized classes, or were on home instruction.
6. Among the rural adult patients, 38 percent had never attended school (23 percent in the urban group); 78 percent had not completed high school (63 percent in the urban group).
7. About half as many of the rural patients had received some vocational assistance, as had the urban patients.

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* Wallace, H. M., Meinert, C. L., and Englund, P. J. *A Study of Cerebral Palsy.* United Cerebral Palsy of Minnesota, St. Paul, Minnesota, 1962, 158 pages.

8. Only half as many of the rural group had ever been employed. These data indicate that persons disabled by cerebral palsy are relatively less likely to receive needed services if they live in rural areas.

In some federal legislative provisions it has been recognized that handicapped rural children and their families are in a disadvantaged position. Extra weighting of rural live births and of the number of children in rural areas is prescribed so that these areas will receive proportionately more federal funds for maternal and child health and for crippled children services. However, this legislative arrangement has not resulted in fully correcting the disadvantaged situation of these children and their families. Lack of coordination between and among agencies, the proliferation of voluntary agencies, and their lack of coordination, the lack of coterminous regions for servicing the state, lack of funds, lack of equally distributed caseloads, and the lack of well-trained personnel all contribute to problems, many of which could be ameliorated by an intermediate level agency to coordinate planning, staffing, and servicing.

There is need to think creatively about roles and responsibilities if adequate services are to be developed for handicapped persons. Roles can, do, and should change. A generation ago schools faced the problems of school lunches, recreation activities and library services. The schools' responsibilities in these areas have today become quite clear and well established. At the present time bits and pieces of programs for handicapped children are developing under many sponsors and many motivations, but coordination of these programs and clarity and conviction as to long range responsibilities are often lacking. Leadership is needed to encourage the matching of agency capabilities to agency roles in order to carry forward a complex of programs to the higher levels of responsibility and service that are now practically possible. Coordination and supplementation of fractional programs are needed, not because those programs were individually poorly conceived or poorly delivered, but because they are not related to the full range of needs, and a balanced service program is not achieved. Uncoordinated activities in a community or geographic area leave the community or area unprepared to adapt to changing concepts and conditions, leave low incidence needs unmet, waste leadership, professional talent and other resources. Attempts should be made to list the types of services that effectively can be retained at the local community level, established at the intermediate level, or held at the state level. Any list of functions that is intended to indicate which ones would be best offered or controlled at the various possible levels of operations must be presented as very tentative. Local practices and traditions can make great differences in such a list. For example, although transportation of patients might usually be considered a function to be controlled in the local community, a state medical center might have already established a transportation system to bring patients to the center or return them to their homes. This state level service might not preclude providing transportation at the local level, but at the same time it should not be eliminated merely because it does not fit what might be considered a normal format. When a service or resource is already established and operating in a community it should be preserved and integrated with the other services and resources contemplated in order to complete a full range of services.

The following table suggests some distribution of services among the local, intermediate and state levels.

TABLE 1

Suggested Location of Comprehensive Preventive and Rehabilitative Services for Handicapped Children and Youth

Local	*Intermediate*	*State*
Maternity and newborn care (preconceptional, prenatal, intro- and post-partum, neonatal)	Consultation by qualified obstetricians and pediatricians	Standard setting hospital consultation, evaluation
General health supervision and care: physicians, dentists, PH nurses, well-child conferences, schools, etc.	Consultative and supervisory staff	Standard setting, evaluation
Case finding		
Counseling and referral services	Regional teams for special diagnostic and rehabilitation services, specialized surgery	Standard setting, consultation, financial aid
Education in regular class or in special class for the more prevalent types of handicaps.	Education in special classes or special schools	Standards, consultation, financial aid
Therapy services	Supervision of therapy services, some direct services provided	Standards, consultation
Day care		Standards, consultation
Welfare assistance	Supervision of welfare programs	Standards, consultation, financial aid
Recreation	Consultation	
Homemaker services	Supervision of homemaker services	Standards, consultation, financial aid
Foster homes	Temporary foster homes to be near diagnostic and rehabilitation services	Standards, consultation, financial aid

Table 1 Cont.

Local	*Intermediate*	*State*
Transportation		Standards, consultation, financial aid
Vocational counseling and orientation	Vocational services including sheltered workshops	Standards, consultation, financial aid
Prevention primary and secondary	Prevention-secondary	Consultation
	Other specialized services furnishing, fitting, and training in prosthesis—specialized laboratory (PKU, Rh, genetics, etc.)	Consultation
Public education	Consultation, supervision	State wide planning
Parent groups	Parent organizations	Parent organizations
Local council or committee	Regional council or committee	State council or committee
Vocational information and counseling of potential professional students	Recruitment and training of personnel	Planning training of personnel
Cooperation with research	Research	Research

There are some steps of an administrative or structural nature which should be emphasized if intermediate units are to be established and maintained successfully. Top level, state planning is required if intermediate units are to develop adequately. The departments of state government that have responsibility for the programs should be well coordinated at the state level. They should cooperatively plan, seek legislation, set policy, and direct research related to intermediate units and their functions. They should cooperatively study the needs of and give supervision to these units. National and state actions can promote and sometimes are essential to the establishment of certain intermediate level resources. National organizations and federal bureaus should affirm positive policies encouraging coordinating operations. Where money grants are involved they can be used to encourage or require cooperative situations when they are indicated. Often one department of a state must take the basic responsibility for the general functioning of an intermediate level center. This suggests a division of the administrative and the technical controls in a multidepartmental entity. This is a difficult division to define, to plan, to get accepted, to establish, and finally to operate.

Community planning agencies should establish a statewide consultation and planning mechanism. Community health and welfare councils and similar groups plan private social services for the community and play an important role in many types of service to persons who are handicapped. Planning councils are often linked with united fund raising agencies and are in a position to influence many voluntary groups and to draw influential individuals of the community into their activities. A state level mechanism for voluntary planning organizations would permit coordination beyond the single community level and would also permit joint planning and research activities with the public state departments. Pilot projects designed for ultimate take-over by public agencies could be better designed and could be more nearly assured of acceptance by the public department if jointly designed.

Voluntary agencies, associations of parents of handicapped children and youth, and similar organizations might well form a state federation or council. This would permit easier coordination of plans, legislative objectives, service programs, research, and recruitment. Such a federation or council could promote coordination with state agency programs and would afford opportunity to deal with united community funds more efficiently. It could be very effective in cross education among the diverse voluntary organizations and could assure better understanding of their programs at grass roots level.

State departments and voluntary organizations with intermediate unit structures or responsibilities should form coterminous regions and coordinated service programs in those regions. Some progress has been made in this respect in such fields as water supply, sanitation, sewage disposal, recreation, police services. The needs in health, education, and welfare are no less urgent; the indication for their regional coordination is no less clear. If agencies and organizations serving a wide range of needs were to offer those services in coterminous regions many benefits to confused patients, clients, and parents could accrue. Centers of services could more easily be established and publicized to potential clientele.

Some state bureaus establish a number of area offices or supervisory or service centers. When this is done by several bureaus in a state their locations should be such as to permit maximum coordination of the various functions thus decentralized. The regions that they serve should be coterminous, and the image of these grouped centers should be of a comprehensive integrated unit. Area offices of the state division of vocational rehabilitation, mental health centers established by the state department of mental health, area supervisory offices of the state welfare department could be located in the same town, perhaps in the same building where some administrative and receiving services could be shared.

If voluntary agencies have offices, these too could be more effective if located in the same town with the offices and centers established by the state departments. Groups of communities planning joint services should be persuaded to locate them near and relate them to the state and voluntary agency offices and centers. These offices should be trade-and-transportation-area centered. This will encourage a higher rate of use and will cause children ordinarily not being served to find their way into the service center that could help them.

State legislation pertaining to handicapped children and youth should be drawn in comprehensive form whenever possible. Legislative provisions which have been made for the various types of handicapping conditions have usually grown up in a piecemeal fashion. Programs supporting public school classes, institutions, services in the home, medical facilities, financial support, agency services, etc., have each come as a particular need was felt or as groups or individuals became vocal and active. Usually such legislation followed pressure from a particular group interested in a particular problem. Like Topsy, the accumulation of discrete legislation grew without an overall plan. It became a patchwork. But no matter how many patches are applied, some weak spots always remain. It requires a comprehensive, omnibus type of legislation to integrate adequately and give stability to services for handicapped children and youth.

Furthermore, many children who are handicapped present a number of disabilities. Categorical legislation inhibits proper treatment and planning for these youngsters. It makes difficult the kind of comprehensive community program planning that would be most effective. Comprehensive legislation would make it easier to establish the type of intermediate regional units being considered here. It would tend to eliminate limitations on needed services and would encourage seeing each patient or client as a whole person.

An equalization principle should be applied in state aids to local and intermediate level programs. There is a lack of uniformity among communities and regions with respect to economic resources and development. Frequently those regions in greatest need of expensive services are those least able to support them.

Programs for handicapped children should be administered at intermediate and local levels. They should not become mere satellite state operations. Obviously, the state will need to set minimum standards, encourage professional development of all staff, and be responsible for most research and training. But in most aspects, facilities and programs developed at local and intermediate levels should be locally controlled.

Existing community agencies should attempt to extend their effectiveness by working with other voluntary and public agencies in the geographic areas around them. The total needs of the children of any community are likely to be beyond the capacities of that community, and certainly of any one agency in that community, to serve them. All resources that are available or might be made available should be involved. Enlightened leadership in a number of contiguous communities is needed to develop and maintain an intermediate supervisory and service unit.

Stable, competent and adequate agency staffs are essential to effective coordination and improvement of services. The most important requirement of any successful operation is a staff that is large enough, stable enough and well enough trained to deliver the services it is charged with giving. Salaries are important to insure meeting this requirement, but working conditions, good administration, well-defined programs, training and development opportunities are also important. These factors should be given primary consideration when a regional unit is organized.

In establishing and operating intermediate units, many very basic difficulties must be overcome. They can be overcome only if the motivations towards the goals are sufficiently strong and if there can be acceptance of the premise that only through cooperative action will the goals be reached. An intermediate unit may be helpful in circumventing many problems of coordination, but it is not a cure-all. Unfortunately, the professional people who must work with each other have usually been trained in curricula that have not stressed multiprofessional operation. This is a serious defect in current training programs and one to which many university leaders are giving serious consideration. Professional and administrative leadership is needed which can recognize the need and provide the technique for democratic action; which can accord appropriate recognition to already operating community organizations and programs; which can help all members of the cooperating staff and feel an identity with a satisfying status in the group and its tasks; which can apply the principle that the clientele is of basic and first importance. To achieve and maintain such leadership broad training would be helpful, but incentives and communication are also essential. Vested individual and professional interests, special vocabularies, resistance to compromise, dilution of individual prerogative and responsibility—all these must be accommodated and somehow kept from destroying the effectiveness of the joint enterprise. Small-community jealousies and competitiveness make the location of any area office or service a major decision and one involving political considerations. Local economic (trade) consequences and easy accessibility to the new services or office are dividends collected by the community where they are located. Only the most responsible, able, and persistent leadership can achieve the kind of grouping that will approach the ideal of integrated, coterminous operations, distributed for maximum effectiveness.

GUIDELINES FOR ACTION

1. An intermediate level coordinating entity (one that is between the state level and the community level) should be considered when the incidence of children and youth with handicapping conditions is too low to permit providing comprehensive and essential services in each community; when qualified professional and administrative personnel are scarce; when needed services are scattered and unrelated.

2. Such an agency should cover the full range of needs rather than represent splinter groups which may provide an incomplete patchwork of services.

3. Creative thinking about the roles, responsibilities, and interaction of groups concerned with handicapped children should re-evaluate traditional functioning and suggest new formats.

4. Top level planning, both in governmental and voluntary agencies, is necessary to coordinate regions and communities adequately and to help them clearly define responsibilities and services best fitted to each level of activity.

5. Interdepartmental coordination at the state level will set the stage and should offer inducements to coordinate at the intermediate and local levels.

6. When multidepartment state offices are established usually one department should be charged with administrative and housekeeping functions. Technical controls and operations should remain in the various departments whose proper functions they are.

7. Programs for handicapped children should be administered at intermediate and local levels. The state should set minimum standards, encourage professional development of staff, and be responsible for most research and training, but should not allow the local units to become mere satellites of the state operations.

8. Since it is difficult for rural families to have ready contact with needed facilities, these facilities should be made more readily available to them through an integrated, intermediate level (regional) agency. Cities should give support to the establishment of adequate services for handicapped children and youth in rural areas as well as in their own metropolitan areas.

9. Statewide federations and planning mechanisms should be established for (a) community planning agencies and (b) associations of parents and volunteers.

10. Certain legislative considerations should be encouraged: (a)

state legislation pertaining to handicapped children and youth should be drawn in comprehensive, omnibus form to insure a well-coordinated, full range of services; and (b) because of the lack of uniformity of economic status of communities, an equalization principle should be applied in distributing state aid among regions for services to handicapped children and youth.

11. Certain geographical considerations should be encouraged: (a) it is preferable for state departments with field or district offices to develop coterminous geographic areas of administration; (b) intermediate units should be located at natural and established communication, trade, and transportation centers; and (c) voluntary agencies and community services should be located where maximum coordination is possible with field offices of state departments and intermediate units of coordination.

12. Major attention should be given to recruiting, retaining, developing, and challenging competent staffs for intermediate units.

6

Comprehensive Diagnostic and Treatment Centers

During the past few years there has been an increasing recognition of the need to establish comprehensive diagnostic and treatment centers to meet some of the deficiencies of disparate, specialized agencies in serving handicapped children and youth. There is general agreement that handicapped children often present a wide complex of problems, multiple in nature, and that many advantages can accrue to the patients, their families, and their communities if the integrated skills of essential specialists can be brought to bear on these problems. However, the norm for diagnosis and treatment is still characterized by a segmented, over specialized approach. There is a lack of synthesis, of central responsibility, of guidance to families and schools and communities, and a loss of effectiveness. Comprehensive diagnostic and treatment centers offer one means of correcting this deficiency.

Without adequate diagnosis the nature and extent of a disability is not ascertained; the medical, psychological, social, vocational, and educational needs are not known; the treatment and care required cannot be indicated; advice to the family cannot be adequately formulated. It has long been evident that a single specialty, functioning alone, cannot meet the diagnostic and treatment needs of disabled children and youth, even when the presenting condition appears to be only a simple one. Psychological, social, family, vocational, and educational problems are nearly always associated with crippling conditions. These should be diagnosed by specialized persons, and their observations and conclusions should be blended into a comprehensive decision relative to treatment (immediate and long range), training, advice to family and school, and followup.

It is not unusual to find children's diagnostic facilities that have been established to give special attention to children with cerebral palsy, rheumatic heart disease and other cardiac disorders, epilepsy, nephritis, nephrosis, cystic fibrosis, muscular dystrophy, malocclusion, mental retardation, and to those with problems in speech, hearing, vision, and others. Unfortunately, children brought to specialty centers do not usually present a neat, single impairment problem. Their disabilities are complex and their needs can be met only by involving a wide range of specialties in an integrated manner. Even if the medical presentations appear to classify in a single category, associated emotional, social, educational, or vocational problems make every handicapped child's case a complicated one. In some instances diagnostic and treatment centers for children and youth have been sponsored by the Crippled Children's Service, Maternal and Child Health Service, voluntary organizations, medical centers and clinics, and school systems. Although state divisions of vocational rehabilitation usually cannot accept as a client a child under fifteen years of age, they frequently encourage the establishment of child diagnostic and treatment centers because they have a deep interest in adequate restorative and orientation services being given at an earlier age. Vocational factors should be considered early in the life of a disabled child.

Some children, presenting apparent problems in mental deficiency, emotional disorders, communication or specific educational difficulties will often require long term study and persistent followup. These children have unusual needs and a dependable diagnosis is frequently not immediately possible; programing their treatment requires great skill, and frequent re-evaluation of the treatment is important.

In many cases there is a need for sustained support for patients and families over a long period of time. Because indicated procedures are often far from specific, there is need for extended study and experimentation. The problems of these patients extend well beyond the immediate, acute crisis involving medical treatment only. It is of basic importance that these children be located and diagnosis and treatment started as soon as possible after the onset of the disabling conditions.

Hopefully, the use of interdisciplinary services and their broad skills brought to bear early for cases of developing disability would reduce the incidence of patients with highly complex problems. They would afford the means for near-at-home, earlier detection and diagnosis and treatment. This should inhibit exacerbation of what might initially have been manageable problems. Early and competent attention to the ills and disabilities of a child can prevent the development of debilitating attitudes in the patient, his family, his school, and his community concerning the patient's potentials. It can help to avoid family economic distress resulting from years of seeking help. It can possibly avoid educational and social deprivation so frequently experienced by the patient who has to live too long with a chronically handicapping condition that is untreated. The disabled child who lives to be a handicapped adult often represents a failure from too little help, too late.

In some sections of the country, comprehensive services for children and youth might possibly be found in such quantity and quality that special centers are not indicated. But generally this is not the situation. Rural areas are typically not well served. There is an acute shortage of the kind of specialists needed to serve the very complex cases that are found in substantial numbers in any area. The "center" format for diagnosis, treatment, and care permits limited personnel resources to reach more people more effectively.

A number of factors are for consideration when establishing a comprehensive diagnostic and treatment center. Among the centers that have been put into operation there is no common pattern of organization or staffing; the services offered are not standardized, each has a unique financing base. However, persons who have been involved in planning or operating such centers suggest that as a minimum they should provide for participation by health, education, rehabilitation, organized labor and volunteer groups.

Community agencies and practitioners who might refer patients to the center or be asked to implement its prescriptions should help to plan the center. This would allow for better definition of roles and insure that services most needed would be offered. It would help to insure acceptance of diagnostic findings and of prescriptions.

Relations to local practitioners are very important. When patients go to a distant center for diagnosis or treatment there is the implication that the local talent is not equal to the demands and needs. Failure to anticipate and to allow for possible negative attitudes resulting from this could be detrimental to efficient followup or even to implementation of treatment plans.

In its operations a comprehensive diagnostic center should have a clear statement of what it intends to do and then organize to do that. Every such agency does client work, administrative work and community work. The activities should include or provide for case finding or arranging for referral sources, diagnosis, treatment, care, rehabilitation, teaching, reporting, followup, research and program evaluation. Sometimes it will be advantageous to start with a single diagnostic clientele and later expand to others. If too many problems (staffing, financing, operating, etc.) are encountered too early they can defeat the intentions of the founders of a center.

Case finding should be arranged for before the center is opened. It should have been established that the services to be offered are needed and that those who need them feel that they are needed, or can be led to see the need. If pre-opening coordination has been well done, agencies and individuals from whom referrals are anticipated will have indicated what services their clientele need and will use. If treatment is to be done in the home community, based on the diagnoses and recommendations from the center, there should be assurances that the required resources are in the community and that the family, local physicians, social workers and educators will accept and act upon the treatment recommendations.

Considerable support can be given to the suggestion that comprehensive centers should be established in connection with teaching hospitals and medical schools, when available. In such a setting the main interest might not be in service, but in teaching and research. The basic purpose would be to make an investment that would pay off in the future through better trained clinicians and improved methodologies. Physicians, psychologists, speech pathologists, social workers, and educators should be trained in comprehensive facilities that attract difficult clinical material, where they can learn not only the best techniques in their respective specialties but also become aware of their individual limitations and of the contributions that can be made by others. When they move out into community locations their broad training and understanding might tend to reduce the need for centralized comprehensive service centers. In considering central diagnostic and treatment centers the issue is not so much, "Should they be established?" but, "Is the society ready intellectually, emotionally, and logistically to implement them on a scale broad enough to meet the needs for multidimensional diagnosis and multilateral treatment of a growing population of disabled and ill-managed children?" Perhaps establishing a center would only be substituting individual ineffectiveness at the community level for group ineffectiveness at the center level. Effective functioning does not necessarily follow establishing a structure.

Community Responsibility

It should be the responsibility of the local referring agency to select those cases for referral which cannot be adequately handled by local resources. Although an effort should be made to eliminate the necessity of parents going from one agency to another in search of advice, the diagnostic and treatment center is not a source for each and every problem. The local agency has the responsibility to explore and utilize local facilities where appropriate. Early detection of those complicated problems which are hard to diagnose is particularly desirable. Adequate basic information on each patient and his family should be provided by local community resources. A thorough case history, medical reports, school information, a description of local efforts to handle the problem, and an evaluation of local resources will facilitate procedures at the center. Some families will not be cooperative. They will not always come to the center with enthusiasm, particularly if public funds and public agencies are playing a major role in providing for the child and in its management. Special procedures are needed in working with such families, and it is the responsibility of the referring agency to make every effort to prepare the family for its contact with the center.

The referring agency, or someone responsible for following through with later recommendations, should be in close contact with the center. Theirs will often be the responsibility for understanding the diagnosis and recommendations and for integrating community resources. The local community should be represented in the final staffing, if not in earlier ones, to provide two-way communication with the center in assessing local resources, information, and background, and in forming plans and following through with recommendations. There should also be provision for feedback to the center from the community. This will tend to apprize the center of deficiencies in its treatment planning and will give information concerning who is responsible for treatment and followup in the various communities.

Because of its ability to make a comprehensive study and bring to bear the abilities and knowledge of a well-trained, interdisciplinary staff of specialists, the comprehensive diagnostic and treatment center is in a unique position to do what most local communities are unable to do in diagnosing difficulties and assessing the medical, psychological, social, vocational, and educational problems and needs of the client. This involves not only the technical skills in diagnosis, prognosis, and prescription for the specific problem creating the referral, but also a recognition of the environmental aspects of the total problem.

Treatment recommendations should be made in consideration of the resources and feasibilities in remote areas to which patients will return after discharge. It has sometimes been suggested that the home-community public health nurse, local social worker, teacher, and the patient's family physician should participate in the case conference at the center when the treatment program is designed. This would introduce reality into the recommendations and would insure that they were understood. Results, interpretations, and recommendations should be reported to the home-community agencies or individuals that have responsibility for implementing the treatment program. They should also go to the family. Clinics, health centers, private practitioners, schools, rehabilitation counselors, social workers might all be involved in the treatment program. They cannot cooperate in it if they are not aware of it or do not understand it. The report should therefore be written with sufficient information and in language appropriate to the individuals or agencies who will be implementing the recommendations. Long delays between the referral date and the date of the appointment are to be avoided. Frustration to the family and the referring agency alike often follows such delays. Similarly, long delays between the time the patient is seen at the center and the time the report is sent out force a local agency to make decisions sometimes without benefit of the recommendations of the center staff.

There is a moral requirement placed on professional workers and institutions that they must make their work effective. Every service or agency is part of a larger social, health, and welfare system. The subparts are interacting and interdependent. To insure the strength of the system each agency must do community work essential to its client work functions. It should have a stated community work policy. It should have formal and informal channels of communication with other agencies and with central planning bodies. Involvement in community planning is not only an opportunity, it is a requirement. Client work should feed information concerning service deficiences in the patient's community to the center, where it should be recorded as part of the patient's file. In turn, it should be sent on to community planning boards. Such information would be effective because it would identify and dramatize the actual problems of people in the community. The community work commitment of an agency makes its staff community minded and discourages insulation and isolation. It should be reflected in job descriptions, inservice training, supervision, evaluation, reporting, budgeting, board meetings, etc.

The greatest hazard to the effectiveness of centers away from the community is the lack of successful communication between the center and the home community. It has been suggested that this is so crucial that a new job entity—community coordinator—should be established. He would be a member of the center's staff and would be the liaison person between the center and the home community of the patient. He would advise, interpret, and sustain in his relation to the center, to the community, and to the family of the patient. His charge would be to see that the treatment plans were implemented. He would locate cases and help to promote their early referral. He could be the consultant to the family and the schools. He would know the local resources and how to use them. He could interpret the family's problem to friends, neighbors, and relatives. Through this community coordinator, a community rehabilitation corps of volunteers could be mobilized to help in the many things that should be done in a community to help its disabled children and adults. These suggested operations would be a part of the community work of the center. Community work involves interorganizational exchange to facilitate interaction among agencies in a common field. It is the mobilization of community support for the ideology, the program, and the budget of the agency. It undertakes to effect changes in community resources necessary to the agency's program objectives. Advantage should be taken of any climate or interest that would promote interdisciplinary structuring, orientation and practice.

Staffing, both administrative and technical, should be adequate to fulfill commitments. Administrative staff is as likely to be inadequate as technical staff. It is easy for technicians (usually the initiators of centers) to forget that good and prompt reporting of diagnostic results and treatment recommendations are very important and that they require considerable clerical and administrative time. Public-image building, a significant time consuming activity, is often overlooked. Administrators have an important part to play in creating conditions that make it possible to recruit and retain good professional staff. Some services, such as laboratory services, can often be most efficiently purchased from a nearby medical facility by a small and new center.

There has been much speculation and some policy decisions have been made concerning the types of patients that comprehensive diagnostic and treatment centers should serve. Because technical and other resources limit the number of such centers, they should accommodate a clientele they can serve best and for whom other resources are likely to be inadequate. Children with severe, chronic conditions are most likely to have acute related problems. Comprehensive facilities with a wide range of staff specialties, with laboratories, and with research and teaching capabilities should serve these children. Not all of the patients referred to a comprehensive center should be uniformly processed, and the center's programs should vary. Some patients should be studied with a view to providing a treatment plan for implementation in home-community settings. Only limited inpatient or day-patient care should be needed for these patients. Center procedures will vary according to whether a diagnosed condition is immediately correctible or is to receive long-term attention with followup reports. The territory to be served is an important consideration. Inpatient or domiciliary accommodations will probably be needed for referred patients who have to travel a great distance. Much is expected of these centers. They are asked to accept only the most difficult cases; they are somewhat a "court of last resort"; they are expected to produce immediate and dramatic results. Parents search many places for a therapy that will rehabilitate their child. It is to be hoped that through a diagnostic treatment center the parent can feel confident that here at last his child will get treatment if treatment is possible.

GUIDELINES FOR ACTION

1. In planning and establishing a comprehensive diagnostic center:

- A clear statement of philosophy and basic purpose should be promulgated.

- Agencies and professional personnel who might be expected to refer patients or receive them from the center should have a part in planning the center and its program.
- Problems of case finding, referral, communication, followup, and feedback should be anticipated and procedures organized.
- Preference should be given to establishing diagnostic and treatment centers in connection with teaching hospital and medical schools with program emphasis on training and upgrading community services as well as on direct service.

2. The community holds certain responsibilities for the successful operation of such a center.

- It must select those cases for which local resources are not adequate. Early detection and diagnosis is particularly stressed.
- The referring agency must provide adequate case histories, evaluations of community resources, and prepare the families for the visit.
- A representative from the community or referring agency should be present at the staffing conference or a special conference should be arranged to ensure understanding of the findings and recommendations by the person responsible for following through with the recommendations.
- The community agency is usually responsible for implementing the recommendations of the center.
- The community must apply and integrate the community services. One suggestion serving this purpose is procuring a community coordinator to integrate the services.
- The community should provide feedback to the center to apprize them of deficiencies, local resources, needs for followup diagnosis, and so forth.

3. The center holds certain responsibilities to the community:

- To provide a coordinated interdisciplinary diagnostic facility which can assess the medical, psychological, social, vocational, and educational problems and needs of the client referred.
- Optimum value will be derived if diagnostic and treatment centers can be comprehensive with respect to the range of specialties involved at these centers. Each center, however, must deal with those cases it can handle best.
- Community resources must be ascertained in making recommendations for treatment in the community.
- An adequate and understandable report with recommendations for treatment or control should be made directly to the home-community physician, public health nurse, social worker, teachers, vocational specialist, family, or other personnel who can implement the recommendations. It would be preferable to have some such person attending the final staffing session.
- Long delays between referral date and appointment or between examination and report should be avoided.
- Long term study and evaluation and followup should be provided when needed.

- Domiciliary accommodations should be provided when needed.
- Upgrading of diagnostic and treatment practices in home-community settings can be promoted by close communication between the center and the community. Centers located in teaching hospitals and medical schools can do most in this respect.

4. Some of the administrative considerations include the following:

- Operational procedure should clearly set forth the responsibilities, authorities, prerogatives, and limitations of all elements within it.
- A clear understanding should be had with the community as to its responsibilities.
- The types of cases served should be clearly stated.
- Operating procedures should be sufficiently flexible to permit variations in patient processing. Mobile units might be considered where distances are great and local services limited.
- Staffing, both administrative and technical, should be adequate to fulfill commitments and obligations. Sound recruiting and financing practices should be followed.

7

Coordination of Special Education and Vocational Rehabilitation

One of the most promising efforts on behalf of handicapped children and youth can be collaboration between special education and the state vocational rehabilitation program. In Chapter Four of this report is found a summary of the discussion of state interdepartmental cooperation. For consideration here is a special opportunity for cooperation between two divisions of state government usually found in a single state administrative department.

There is usually a division in the state department of education that is concerned with planning, encouraging, financing, and guiding education programs in local communities for children and youth whose needs demand curricula and/or practices beyond the typical, traditional offerings of the public schools. Most states have also included in their departments of education a division or bureau of vocational rehabilitation. These divisions or bureaus of vocational rehabilitation are generally concerned with adults and with those disabled youth who are old enough to be candidates for the work force (age 15 or 16, and above) and who are judged to have some potential for employment.

It would appear that cooperative action between two divisions within a single state department would be relatively easy and effective. Whatever cooperative actions might be needed to insure that handicapped children move efficiently from pupil status in school programs to client status in vocational rehabilitation programs should be easily undertaken in such a situation. But this has not been the case. Effective collaborative arrangements have been sufficiently unusual that when they have occurred they have merited special notice. Most of those which have been reported have apparently been made possible only by a special grant of funds from a federal agency—the Vocational Rehabilitation Administration. Local state resources alone have not generally produced a pattern of services that will permit a handicapped child to move easily from school to employment. Staff persons in state divisions of vocational rehabilitation typically complain that handicapped youths coming to them for vocational services are not well prepared to understand or to benefit from those services.

Explanations for this situation embrace the usual list of inhibitors including specialization in training and lack of communication. However, in this instance there is another factor that might make collaborative action somewhat more difficult. The division for special education at the state level is normally not an operating division in the sense that a program is delivered to a clientele of individuals. The local schools conduct special education programs. The special education division at the state level supplies consultation, advice, standards, allocation of state and federal funds as provided by statutes and regulations. The division of vocational rehabilitation, on the other hand, is an operating division. Services are delivered directly to clients. The difference in modes of functioning can introduce special difficulties in making collaborative arrangements between these two state divisions. There has been such an obvious need for close cooperation between the two programs that some states have taken the steps necessary to effect this cooperation. In at least two states, Texas and Minnesota, the divisions of special education and vocational rehabilitation have been placed under a single assistant commissioner of education. With such an arrangement, cooperative functioning is almost impossible to avoid.

In the American democracy, cultural institutions have been structured to meet the needs of the majority of the people they serve. Schools address their programs primarily to the great middle range of pupil capacities. Special education is designed to meet the needs of children whose physical, mental, social, emotional and educational characteristics are outside this middle range. These are exceptional children and their numbers and needs are very great. In considering these needs it should be emphasized that they are fundamentally the same as for all children. These children need "opportunities... to realize their full potential for a creative life in freedom and dignity." For handicapped children and youth it is not enough that the schools offer them traditional academic training, even though it might be specially designed so that they acquire an optimum academic status. The importance of adequate academic training should not be underemphasized for these children; but they also need special preparation for the special problems they must face after leaving school. Graduating young people generally face a socioeconomic milieu that is best able to accommodate the middle range of physical and mental capabilities. By definition, handicapped youth are those not easily accommodated. Their transition from school to employment is more difficult. The schools, through special programs, should undertake all possible procedures to reduce that difficulty.

For handicapped young people, vocational rehabilitation means assistance in facilitating the special adjustments that they must make to achieve a satisfactory socioeconomic status. But the problems incident to rehabilitating young handicapped people can be greatly diminished if those problems are anticipated while they are in a school environment. Divisions of special education and of vocational rehabilitation, working closely together, can insure that the difficulties of a handicapped child in moving from school to the work force will be considerably reduced.

In most states the division of special education and local school officials have shown that much can be accomplished by educable mentally retarded children if they are exposed to special curricula and special methods. Too often, however, the emphasis has been on academic attainment alone. For these children the meeting of their specific educational needs is not enough. Without special emphasis, their vocational interests and capacities will not develop adequately and timely. School administrators and teachers typically welcome the intervention of other agencies that can help with the vocational planning for retarded children.

Mentally retarded children will usually require a longer time to establish the habits necessary to success in employment. Special education and vocational rehabilitation cooperation is of great importance because it provides an earlier introduction to vocational orientation and basic work skills. While these children are in school it has been found advantageous to give major attention not only to social maturity, self-care, communications, social competence, and self-direction, but also to:

1. Vocational diagnosis and evaluation of employment potential by and with vocational rehabilitation specialists.
2. Actual job try-out and job training under the direction of vocational rehabilitation staff.
3. Job placement and supervision by vocational rehabilitation personnel.
4. Exposure to a curriculum developed jointly by special education and vocational rehabilitation specialists to train pupils prevocationally.
5. Full utilization, with the advice of vocational rehabilitation staff, of job training resources that exist within the school plant, e.g., school nurse's office, school garage, school cafeteria, school custodian's shop.
6. Expansion of the school work to include the whole community for job observation, learning work habits, relating to work foremen, and to as many others as possible.

It is necessary that the urgency of vocational experiences for the child be balanced by the requirements for certain basic academic work demanded by most states for granting certificates and diplomas.

Academic status, including such symbols as certificates and diplomas, is as important in the career of a disabled individual as it is for one not facing the problems imposed by disability. Work opportunites sometimes have to be created in order to afford a satisfactory range to meet the interests and abilities of the clients of an education-vocational-rehabilitation program. The business-professional-industrial community often does not furnish a wide variety of work training situations. The maintenance and service activities of the schools themselves typically will offer only limited potential. The establishment of special workshops will sometimes be indicated.

Children who have disabilities other than mental retardation also present special obligations and opportunities for joint action through special education and vocational rehabilitation programs. [illegible] these children as with the mentally retarded, special attention should be given to neutralizing the negative assumptions concerning vocational potential that they often absorb from their families and others. This requires unique curricula and work-study arrangements designed to develop and emphasize abilities that might not otherwise be recognized. It requires aggressive work with parents and teachers and the general population of the community to promote optimism and positive expectations and needed skills. Both the special education and the vocational rehabilitation programs have essential roles to play in the development of these children.

For all disabled children, vocational orientation should begin early so that there can be ample preparation to meet the special problems they must face in adjusting to the demands of work and to the community attitudes and assumptions concerning disabled workers which they must meet and help to change. Disabled children who go to school demonstrate by that accomplishment itself that they have what is necessary to graduate to the work force. A greater challenge is presented by those who are so mismanaged or so disadvantaged that they do not get to the schools. Essential individual arrangements for case finding, evaluation, mobility, family cooperation, and challenging work-study curricula, can be effected for homebound or near homebound children if the resources of both the schools and the vocational rehabilitation division can be brought to bear in an integrated manner.

Experience in cooperative arrangements between special education and vocational rehabilitation has revealed that certain additional considerations must also be given high priority if difficulties are to be minimized. One of the problems in such a joint effort is that of communication among specialists. People trained in specialties often find joint functioning more difficult than do others who are less well trained. Not only specialized vocabularies, but specialized clinical methods, limited areas of interest and concepts taken for granted tend to thwart communication. Already-on-duty staff who will be utilized in each agency are often found to be lacking in the basic concepts and techniques of the cooperating agency and its staff. Well planned inservice or preproject training is essential. Some of this should be of a formal type. Cross training eases the persistent problem of communication. It can generate an appreciation of the goals, roles, problems, and accomplishments of the cooperating agencies and technicians and develop the kind of respect that must be mutual if cooperative action is to be efficient. It can often reveal new meaning and new opportunity for the specialist in his own specialty.

A well conceived program of joint action can fail because trained personnel are not available for balanced staffing. In teamwork there should be a democratic method in procedure, but this cannot obtain if there are wide differences in competencies. There will sometimes be need to adjust the regulations or traditions of one program or the other in order to make it possible to serve all the clientele that might benefit from an integration of special education and vocational rehabilitation. Cooperative programs are less flexible than individual programs. When two or more must move and change directions and accelerate or decelerate together these actions become more cumbersome. However, when working with a disabled person he must be seen globally as a whole person; he is not divisible. His needs can best be served by a team of competent specialists working together. When this is done, conditions that might go undetected and that would inhibit progress towards a rehabilitation goal can be recognized early and be effectively treated. The cooperation among agencies offering programs for handicapped children and youth should extend to all categories of disability. Sometimes, because of the aggressiveness and helpfulness of a special interest group, arrangements are made to initiate an effective cooperative pattern of services for a single diagnostic clientele. The momentum of such a move should carry service planning for any disadvantaged individual. When a format is being established for cooperative action its value and utility can be broadened and support for it can be strengthened if all types of special needs and special interests are served. Any new format for operating requires planning. And planning is a sophisticated activity. It is characteristic of only the highest order of civilized functioning. So it requires extra effort even among educated human beings to plan their work, to anticipate the problems that any undertaking entails, and to provide for avoidance of penalties incident to an inadequate meeting of unanticipated emergencies.

One of the greatest essentials of collaborative programing is good leadership. If this element is available, great achievement is possible.

But if it is lacking the best of plans cannot be implemented nor can they make a successful program. Standardizing, policymaking, legislating, training, and managing funds might all be well done, but without leadership of a high order, the undertaking will not yield what it should. Good leadership can mobilize the many interests that are needed to bring to fruition the efforts of special education and vocational rehabilitation agencies to help disadvantaged children and youth. These include organized labor, industrial and trade groups, employers' organizations, education associations of various types, medical, psychological and other specialty associations, parents' and teachers' associations, religious groups, chambers of commerce, as well as the existing, designed-for-rehabilitation resources found in some communities.

One of the hazards encountered in staging joint enterprises is the difficulty in enlisting the essential aid of persons and agencies that do not view the task with the enthusiasm or the urgency of the principal parties. Frequently they are only ancillary to health, education, welfare, and rehabilitation programs. They have other obligations and duties that they regard as more fundamental to their basic missions. They do not press as hard to secure the favorable interpretations of laws and regulations that might be needed. They do not join easily in seeking additional legislation when that is needed to make a program possible.

Many of the problems and opportunities presented in this discussion of collaborative action between special education and vocational rehabilitation have anticipated an effort that is statewide and comprehensive in scope. However, in many states it will not be possible to proceed so ambitiously, immediately. Several compromise arrangements have been effected in various parts of the country. They all represent forward movement, although some are somewhat less than definitive. In Minnesota and Texas, special education and vocational rehabilitation at the state level have been placed under the direction of a single assistant commissioner of education. Statewide programing should be easier under such an administrative plan. In some states beginnings have been made in individual cities; Detroit and Oklahoma City are examples.

Considerable collaborative action can be brought about by formal agreements among departments at the state level, as in Georgia. In many states there are informal working arrangements that are producing good returns. Sometimes merely a joint advisory committee of professionals and laymen can promote joint activity at the operating levels. Whatever arrangement is made, if the goal is to enhance the opportunities of handicapped children for productive, satisfying lives the outcomes can be positive in terms of basic education and vocational rehabilitation goals. Under any kind of an administrative format there can be implementation of the general objectives of education for disabled children and youth. It takes no great genius to recognize, and no highly complex organization to emphasize, that school training is not for academic excellence, per se, but it is for the preparation of the individual to live successfully in our times. Specialists in vocational rehabilitation can be very helpful in this preparation in the early years of a disabled individual. It requires no great imagination on the part of those in vocational rehabilitation to perceive that the school years are crucial years for ultimate vocational adjustment. It is an inevitable imperative that special education and vocational rehabilitation specialists and agencies must relate their services so as to form a unified intregrated program for the benefit of handicapped children and youth.

GUIDELINES FOR ACTION

1. Divisions of vocational rehabilitation should work very closely with programs of special education to insure an easy transition by disabled young people from pupil status to the status of worker in the work force.

2. The special difficulties that handicapped children will have when they undertake to enter the work force upon attaining work force age should be anticipated and provided for from an early age.

3. Schools should encourage an attitude of optimism and adequately high and realistic vocational expectation in handicapped children, their families and various professional persons who are working with them.

4. Schools, in consultation with vocational rehabilitation specialists, should make special efforts to give handicapped children and youth work experiences both within the schools' maintenance and service operations and in the community. These will often be needed to provide the work experiences that other children normally get but that are denied handicapped children.

5. Special education and vocational rehabilitation programs should cooperate in finding, evaluating, motivating, training, and developing youngsters so severely disabled that they do not enter the traditional school curriculum.

6. Procedures for and commitment to cooperative action should be established at all levels of the special education and vocational rehabilitation programs.

7. Administrators in special education and vocational rehabilitation should recognize and provide the staffing for the added work involved in cooperative enterprises.

8. The specialized personnel in special education and vocational rehabilitation should be oriented to accept many nontraditional duties and responsibilities. However, they should not be encouraged or permitted to take initiative in areas in which they do not have competence.

9. Inservice training should precede cooperative undertakings that are to be extensive and are to be continued over a long period of time. This training should emphasize objectives, opportunities, roles, etc.

10. Written agreements and operational descriptions should be prepared in detail for the cooperative relationship between special education and vocational rehabilitation. They should set forth policies, responsibilities and joint, and separate duties. They should be sufficiently flexible to meet variable and dynamic requirements and to avoid being threatening to the participating agencies.

11. In their cooperation, special education and vocational rehabilitation should involve any other voluntary or public agencies or resources that might be essential or useful in promoting the interests and meeting the needs of handicapped children and youth.

Appendix A
Steering Committee

William C. Geer, Chairman, Executive Secretary, The Council for Exceptional Children

James F. Garrett, Assistant Director, US Vocational Rehabilitation Administration

Mamie Jo Jones, Past President, The Council for Exceptional Children

Arthur J. Lesser, Director, Division of Health Services, US Children's Bureau

Romaine P. Mackie, Chief, Exceptional Children and Youth, US Office of Education

Rozelle J. Miller, Supervisor, Special Education, Maryland State Department of Education

C. Esco Obermann, Past President, National Rehabilitation Association

Norman Pierson, Director, Washington, D.C. Department of Vocational Rehabilitation

Dean W. Roberts, Executive Director, National Society for Crippled Children and Adults

Jayne Shover, Associate Director, National Society for Crippled Children and Adults

Jean R. Stifler, Chief, Maryland Division of Crippled Children and Heart Disease Control

E. B. Whitten, Executive Director, National Rehabilitation Association

Appendix B
Agency Participants in Preliminary Conferences

Atlanta

- Bobby Dodd Sheltered Workshop
- Emory University Psychiatric Clinic
- Foundation for Visually Handicapped Children
- Georgia Association for Retarded Children, Inc.
- Georgia Department of Public Health
  - Dental Health Services
  - Health Conservation Services
  - Analysis and Planning Service
  - Community Mental Health
- Georgia Heart Association
- Georgia Society for Crippled Children and Adults, Inc.
- Georgia Society for the Prevention of Blindness
- Atlanta City Board of Education, Program for Exceptional Children
- Southern Regional Education Board
- Georgia State Department of Education
  - Division of Instruction
    - Guidance and Testing
    - Services for Exceptional Children
  - Visiting Teacher's Association
  - Division of Vocational Rehabilitation
- The National Foundation
- The University of Georgia, Program for Exceptional Children
- U. S. Children's Bureau

Baltimore

- Maryland Society for Mentally Retarded
- Baltimore City Hospitals
- Baltimore Hearing Society, Inc.
- Baltimore League for Crippled Children and Adults
- Maryland State Department of Education
- Montebello State Hospital
- Maryland Division of Vocational Rehabilitation
- Baltimore City Health Department

Baltimore Special Education Department
Goodwill Industries of Baltimore
Maryland State Employment Service
Maryland Society for the Prevention of Blindness
Heart Association of Maryland
The National Foundation
National Rehabilitation Association
Maryland Division for Crippled Children

Minneapolis

State Department of Education
    Vocational Rehabilitation and Special Education Division
State Department of Public Welfare
    Crippled Children's Services
    State Services for the Blind
    Services for Retarded Children
Minnesota Congress for Parents and Teachers, Inc.
Minnesota Society for Crippled Children and Adults
Gillette State Hospital
University of Minnesota
    Department of Special Education
    Department of Physical Medicine and Rehabilitation
Minnesota Association for the Mentally Retarded
Minneapolis Hearing Society
Kenny Rehabilitation Institute
State Department of Health
Minneapolis Rehabilitation Center, Inc.

San Francisco

California Conference for California's Exceptional and Rehabilitation Needs
California Conference of Sheltered Workshops
California Coordinating Council on Handicapped Children
California Council for Retarded Children
California Department of Industrial Relations
California Department of Mental Hygiene
    Bureau of Social Work
    Children's Services and Retardation
California Department of Public Health
    Bureau of Crippled Children Services
California Department of Social Welfare
California Mental Health Association
California Parents Teachers Association
California Society for Crippled Children and Adults
California State Department of Education
    Division of Special Schools and Services

California Vocational Rehabilitation Service
    Workshops for the Handicapped
    Advisory Council
California Youth Authority
Chests, Councils and Funds of Central and North California
Community Rehabilitation Industries
Council for Exceptional Children
Mental Retardation Information Council
Palo Alto School District
San Francisco Aid to Retarded Children
San Francisco Society for Crippled Children and Adults
San Francisco State College
State Department of Education
United Cerebral Palsy Association of California
U.S. Children's Bureau
U.S. Office of Vocational Rehabilitation
University of California School of Social Welfare
Young Men's Christian Association

Appendix C
Members of Special Study Committees

Cooperation Among Voluntary Organizations

Chairman
Gunnar Dybwad, Executive Director,
National Association for Retarded Children
Members
Leo E. Connor, Assistant Superintendent,
Lexington School for the Deaf
New York City
Peter Meek, Executive Director, National Health Council
S[illegible]wood A. Messner, Director, Service Section, Medical and Scientific Department, United Cerebral Palsy Associations, Inc.
Louise Mumm, Staff Consultant, National Social Welfare Assembly
Philip E. Ryan, Executive Director, The National Association for Mental Health, Inc.
Ruth M. Williams, Assistant Executive Secretary, National Conference on Social Welfare

State Interdepartmental Cooperation

Chairman
Evelyn Schilling Thomas, California Youth Authority
Members
William Beach, Coordinator, Children's Services and Retardation,
California Department of Mental Hygiene
Margarete Connolly, Executive Secretary, San Francisco Aid to Retarded Children
Frank Doyle, Chief, Division of Special Schools and Services,
California Department of Education
Charles R. Gardipee, Chief, Crippled Children's Service,
California State Department of Public Health
Morris Grumer, Executive Director, Handicraft Industries,
Los Angeles
Daniel E. Johnson, Coordinator of Special Education,
Alameda County School Department, Hayward, California
Orville Luster, Youth for Service, San Francisco, California

Elizabeth Rhoads, Chief, Bureau of Family Services, California Department of Social Welfare

Phillip Schaeffer, Regional Representative, Office of Vocational Rehabilitation, Region IX, San Francisco, California

Murray Tondow, Palo Alto Unified School District

Coordinating Services at the Intermediate Level

Chairman

Maynard Reynolds, Professor, Education Psychology, University of Minnesota

Members

Richard Bartman, Director of Children's Mental Health Services, State Department of Public Welfare, St. Paul, Minnesota

Wayne Bassett, Member of Minnesota State Legislature, Knobles County Librarian

Frances Coakley, Chief, Section on Mental Deficiency & Epilepsy, Minnesota State Department of Public Welfare

Edward Francel, Associate Professor, School of Social Work, University of Minnesota

Joseph Kahle, Head, Family & Child Welfare Division, Community Health & Welfare Council, Minneapolis

Wayne Larson, Executive Director, Crow Wing County Welfare, Brainerd, Minnesota

C. Esco Obermann, Past President of the National Rehabilitation Association

A. B. Rosenfield, Director of Division of Special Services, Minnesota State Department of Health

Ellsworth Stenswick, Director of Special Education, Minnesota State Department of Education

Comprehensive Diagnostic and Treatment Centers

Chairman

Harrie M. Selznick, Director of Special Education, Baltimore School System

Members

Jay Cherry, Former Director, Baltimore Hearing Society

J. L. Delaney, Supervisor, Vocational Rehabilitation Services, Baltimore

Bruce Eberwein, Executive Director, Maryland Society for Crippled Children and Adults

Kurt Glaser, Maryland State Department of Mental Hygiene

Sara Leiter, Maryland State Department of Education

William Martin, Health and Welfare Council of Baltimore

John Pitts, Bureau of Child Hygiene, Baltimore City Health Department

Jean Stifler, Chief, Division for Crippled Children, Maryland State Department of Health

Benjamin White, Chief, Division of Community Services for the Mentally Retarded, Maryland State Department of Health

Coordination of Special Education and Vocational Rehabilitation

Chairman

Stanley Ainsworth, Chairman, Program for Exceptional Children, University of Georgia

Members

Robert A. Abel Jr., Counselor, Savannah Local Office, Division of Vocational Rehabilitation

Dorothy Ayers, Coordinator, Program for Exceptional Children, Savannah, Georgia

Howard Bright, Rehabilitation Consultant for the Mentally Retarded, Georgia

W. A. Crump, Division of Vocational Rehabilitation, Georgia

Mamie Jo Jones, Coordinator, Services for Exceptional Children, Georgia

Sara Readling, Consultant, Services for Exceptional Children, Georgia

Louise H. Stewart, Executive Director, Georgia Association for the Retarded

Juanita Walls, Chatham County Schools, Georgia

Appendix D
Discussion Group Leaders and Recorders National Meeting in Chicago, March, 1963

Discussion Group 1

Leader

Kenneth Hamilton, Associate Director, Ohio Rehabilitation Center, Ohio State University

Recorder

Reginald Orsolini, Research Analyst, National Society for Crippled Children and Adults, Inc.

Discussion Group 2

Leader

Robert Warner, Medical Director, Children's Rehabilitation Center, Buffalo, New York

Recorder

Eleanor Bader, Program Consultant, National Society for Crippled Children and Adults, Inc.

Discussion Group 3

Leader

Raymond D. Dennerll, Jr., Executive Director, Michigan Epilepsy Center and Association, Detroit

Recorder

Opal Phee, Special Consultant, National Society for Crippled Children and Adults, Inc.

Discussion Group 4

Leader

John Kniest, Executive Director, St. Louis Society for Crippled Children and Adults, St. Louis, Missouri

Recorder

Rhoda Gellman, Program Analyst, National Society for Crippled Children and Adults, Inc.

Discussion Group 5

Leader

T. P. Hipkens, Executive Director, Home for Crippled Children, Pittsburgh, Pennsylvania

Recorder

Eleanor McGuire, Program Consultant, National Society for Crippled Children and Adults, Inc.

Discussion Group 6

Leader

Rudolf P. Hormuth, Specialist in Services for Mentally Retarded Children, Health Services Division, Children's Bureau, Washington, D. C.

Recorder

Eveline Jacobs, Program Consultant, National Society for Crippled Children and Adults, Inc.

Discussion Group 7

Leader

Celia R. Moss, ACSW, Director, Home Care Department, Montefiore Hospital, Pittsburgh, Pennsylvania

Recorder

Florence Stattel, Consultant on Rehabilitation Facilities, National Society for Crippled Children and Adults, Inc.

Appendix E
Authors of Institute Papers

Ainsworth, Stanley. New Approaches to Collaborative Practice—Special Education and Vocational Rehabilitation

Barsch, Ray H. Diagnostic, Evaluation and Rehabilitation Centers for Handicapped Children—Discussant Statement

Bryant, W. D. Coordinating Services at the Intermediate Level—Discussant Statement

Buell, Bradley. Structure and Substance in Interagency Joint Planning and Collaborative Practice

Cain, Leo F. State Interdepartmental Council for the Handicapped—Statewide Inter-Agency Joint Planning Principles and Practices—Discussant Statement

Connor, Frances P. Coordinating Services at the Intermediate Level—Discussant Statement

Douglass, Joseph H. Some Implications for Programing and Joint Planning Among Voluntary Agencies—Discussant Statement

Dybwad, Gunnar. Cooperation Among Voluntary Health Organizations.

Eskridge, Charles. The Texas Plan for Rehabilitation of Mentally Retarded and Severely Physically Handicapped Through a Cooperative Program between the Division of: Vocational Rehabilitation, Special Education and Independent School Districts—Discussant Statement

Fenton, Joseph. A Description of the New York State Interdepartmental Health and Hospital Conucil—Its Accomplishments and Principles and Basic Concepts for Interdepartmental Coordination—Discussant Statement

Hunt, Merrill E. Planning for Comprehensive Diagnostic and Evaluation Centers—Discussant Statement

Karnes, Merle B. New Approaches to Collaborative Practice—Special Education and Vocational Rehabilitation—Discussant Statement

Klapper, Morris. A Discussion of a Report by Gunnar Dybwad on Cooperation Among Voluntary Health Organizations—Discussant Statement

Kurren, Oscar. National Institute on Services for Handicapped Children and Youth—Preliminary Report

Lis, Edward F. Diagnostic, Evaluation and Rehabilitation Centers for Handicapped Children—Discussant Statement

Miller, C. Arden, State Interdepartmental Council for the Handicapped—Statewide Interagency Joint Planning Principles and Practices—Discussant Statement

Murray, Clyde E. A Few Comments from a Community Organizer in the Mental Health Field on Cooperation Among Voluntary Health Organizations—Discussant Statement

Reynolds, Maynard C. (Minnesota Study Committee) Coordinating Services at the Intermediate Level

Samo, Lyman L. Looking at Coordination Through Rose-Colored Glasses—Discussant Statement

Selznick, Harrie M. Comprehensive Diagnostic and Evaluation Centers for Handicapped Children—Principles and Practices for Interagency Joint Planning

Sieder, Violet M. Diagnostic, Evaluation and Rehabilitation Centers for Handicapped Children—Discussant Statement

Slicer, Alfred. New Approaches to Collaborative Practice-Special Education and Vocational Rehabilitation—Discussant Statement

Sokolov, June. New Approaches to Collaborative Practice—Special Education and Vocational Rehabilitation—Discussant Statement

Thomas, Evelyn. (California Study Committee) Report on State Interagency Coordinating Councils on Programs for the Handicapped

Wallace, Helen M. Comprehensive Services for Handicapped Children at the Intemediate (Regional or District) Level—Discussant Statement